Defending an Ethic of Care: An Autoethnography Reflecting on Emotional Health in Critical Care Medicine

by

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Dalhousie University is located in Mi'kma'ki, the
ancestral and unceded territory of the Mi'kmaq.
We are all Treaty people.

Dedication

To the many healthcare providers who have taught me what “care” is and to the people in my life who have taught me what a person needs to feel cared for.

Table of Contents

Table of Contents....iii
List of Figures....vi
Abstract....vii
List of Abbreviations and Symbols Used....viii
Statement....ix
Acknowledgements....xii
Chapter One: Introduction....1
  1.1 My Experiences with Healthcare....2
    1.1.1 My Experience Outside of the Hospital....3
    1.1.2 No Sanctuary: Dealing with Trauma....10
    1.1.3 Initiation to the Hospital: Patient Zero....16
    1.1.4 My Time Spent Working in Hospital....24
  1.2 The Purpose of this Project....30
    1.2.1 Summary of Chapters....33
    1.2.2 Situating the Research/Researcher....35
    1.2.3 Interdisciplinary Research Design....41
  1.3 Methodology and Theory....44
    1.3.1 Retrospective Autoethnography....46
    1.3.2 Data Collection....50
    1.3.3 Data Analysis....56
  1.4 Relational Themes....63
Chapter Two: Orienting Us to The Problem....66
  2.1 "Stress" in the Helping Professions....66
    2.1.1 Getting Clear on Terminology....69
    2.1.2 The Problem....77
    2.1.3 The State of Things....84
  2.2 The Effects of Stress on the Mind/Body....85
    2.2.1 Emotional Strain & Coping Mechanisms....85

2.2.2 Occupational Stress Defined 92

2.2.3 Measuring Stress in Medicine 98

Chapter Three: Awareness 105

3.1 The Intensive Care Unit 108

3.2 Delivering Critical Care 111

3.3 The Structure of the ICU 115

3.4 The Culture of the ICU 117

3.5 The Demands of Medicine 122

Chapter Four: Identity & Integrity 131

4.1 Liminality 131

4.2 Medical Identity 136

4.3 Identity as a Mechanism for Social Belonging 142

Chapter Five: Emotional Labour 146

5.1 Quietly Emotional Caregivers 148

5.2 Emotional Repression 154

5.3 How Resilience Factors In 157

5.4 Empathy: Pro or Con? 166

5.5 Feeling Rules for the "Managed Heart" 172

5.6 The Cost of Alienation 175

Chapter Six: Care Ethics 183

6.1 Who Cares and What Matters? 183

6.2 Tronto's Ethics of Care 187

6.3 Four Phases of Caring 191

6.4 Feminist Contributions 192

6.5 Caring Requires Trust 200

6.6 Learning to Care 202

Chapter Seven: Tying Things Together 207

7.1 Occupational Stress as a Mechanism for Survival in a Hostile Environment 209

7.2 Awareness as a Mechanism for Personal and Social Change 210

7.3 Identity as Social Caste, and Identity as Personal Power 211
7.4 Emotional Labour is What is Exhausting 212
7.5 Alienation as a Side Effect of Rejection, Silencing, and Inauthenticity 214
7.6 Care Work as a Mechanism for Justice, Instead of Oppression 216
Chapter Eight: Conclusion & Discussion: Explicating My Theory 217
8.1 How to Care Better 218
8.2 Ways to Start Caring Now 219
References 222
Appendices 248
Appendix 1: Raw Data and Coding – Samples of the Categorization Process 248
Appendix 2: Thematic Analysis from Coded Data – Qualitative Evidence of Themes 252
Appendix 3: Strategies Nursing Professionals Adopt to Cope with Occupational Stress 254
Appendix 4: Beehr & Newman, The Facets of Job Stress 262

List of Figures

Figure 1: *Gowned and Gloved*, Oil on Canvas, Painting by Joe Wilder, MD, Director of Emergency Services Mt Sinai Hospital New York (Wilder, n.d.). 17
Figure 2: *The Surgeon Placing Sutures*, Painting by Joe Wilder, MD, Director of Emergency Services Mt Sinai Hospital New York (Wilder, n.d.). 19
Figure 3: Surgical Table in the Operating Room, Photographed at Work, Unknown Date. 21
Figure 4: Working in the Operating Rooms, Self Portrait (2018). 24
Figure 5: Dressing for Work in the Operating Rooms, Self Portrait (2022). 52
Figure 6: Series of Journal Entries Showing Early Thoughts About the Medical World– "Notes on Healthcare," 2018 onward. 55
Figure 7: Themes Causing Burnout and Moral Distress in ICU (taken from Hancock, et al., 2020, p. 1543) 82
Figure 8: Image of an empty intensive care unit room with the bed and monitors neatly prepped. Photo taken by Hillary Ferguson in the ICU. 108
Figure 9: Adobe stock photo, royalty-free, Dec 22, 2020, "The exterior of the hospital building at night. Aerial view of the windows of hospital wards in a clinic" from: https://www.google.com/imgres?imgurl 120
Figure 10: *Cardiac Surgery*, Painting by Joe Wilder, MD, Director of Emergency Services Mt Sinai Hospital New York (Wilder, n.d.). 152

Abstract

Occupational stress is widely experienced. Receiving adequate support for occupational stress is not. While a healthy recovery from occupational stress is possible, developing maladaptive coping strategies to mitigate occupational stress is common for healthcare providers. Specifically, critical care workers are uniquely positioned in that they must care for profoundly sick patients under extreme working conditions, such as high work strain, workload, and work responsibility. All of this leads to high levels of stress. These stressors, if ignored, can contribute to disordered ways of operating in the workplace, such as learned helplessness, dissociation, and self-neglect. Ideally, an individual's feelings are addressed prior to the onset of protective behavioural mechanisms, such as withdrawal or avoidance. However, early intervention requires *acknowledging* an individual's exposure to significant workplace stress, a practice that is not yet commonplace in Canadian hospitals. The primary goal of this research is to understand occupational stressors in critical care medicine using self-study or autoethnography.

This research is qualitative and involves the use of retrospective self-observation for data collection, and thematic analysis for sorting and examining the data. I present a case for how care ethics (CE), which emphasizes the significance of relationships to ethical thinking, and trauma-informed care (TIC), which emphasizes the use of compassion towards traumatised individuals, are frameworks that better address caregiver distress than alternative models such as resilience or positive psychology. By weaving together theoretical work, empirical work, and my reflections as a health care worker, I provide evidence to answer the following research questions: (1) Do repressed, ignored, or unprocessed emotions contribute to occupational stress in critical care? (2) Does the culture of shame in contemporary medical institutions contribute to/perpetuate occupational stress? (3) Can a critical examination of personal experience (what is felt by a single healthcare worker) teach us about occupational stress?

The evidence presented in this project indicates that while the causes and symptoms of occupational stress are varied, six core themes show striking positive and negative correlations with stressful situations in the ICU. These core themes highlight specific aspects of critical care delivery that must be better understood to address the problem of occupational stress, each theme representing a unique and salient property, and acting as touchstones for analysis. The themes include (1) the effects of the workplace on personal *identity*, (2) the extent of personal *awareness* on the job, (3) the extent of *emotional work* required, (4) the degree of trust and wholeness (or *integrity*) felt in the workplace, (5) the degree of *alienation* or a problematic disconnection from the fruits of one's labour that is experienced, and lastly, (6) the overall meaning given to the *care work* conducted. The six core themes provide a launching point for a concluding discussion on what is needed to support and maintain a healthy work environment.

List of Abbreviations and Symbols Used

BOS – Burnout Syndrome
CC – Critical Care
CE – Care Ethics
CPR – Cardiopulmonary Resuscitation
CCNP – Critical Care Nursing Program
CT – Computed Tomography
DP – Depersonalisation
ECMO – Extracorporeal Membrane Oxygenation
ED – Emergency Department
EE – Emotional Exhaustion
ENT – Ear, Nose, Throat
FLO – Front Line Ownership
GAD – Generalised Anxiety Disorder
HSM – Health Service Manager
ICU – Intensive Care Unit
IE – Institutional Ethnography
MRHP – Most Responsible Healthcare Provider
MRI – Magnetic Resonance Imager
NF – Necrotising Fasciitis
OMF – Oral-maxillofacial
OR – Operating Room
OS – Occupational Stress
PA – Personal Accomplishment
PACU – Post Anaesthesia Care Unit
PTSD – Post Traumatic Stress Disorder
PTG – Post Traumatic Growth
REB – Research Ethics Board
RTA – Reflective Thematic Analysis
TA – Thematic Analysis
TIC – Trauma Informed Care
VON – Victorian Order of Nurses

Statement

This project is a retrospective self-study which means that there are no active research participants beyond the principal investigator. Even though I, as both the principal investigator of this research and the author of this dissertation, draw specifically on my own experience as evidence to support the arguments made here, this research data does peripherally include other individuals given the fact that these stories were not experienced in isolation. Thus, despite being the only technical participant in this project, I have still decided to gain informal approval (i.e., through community engagement) from the main community being investigated i.e., the community of Critical Care Medicine. Further to this, this project does have research ethics approval from my institution (REB #2022-6456).

Collecting individual informed consent from participants is always preferential when conducting research since informed consent is the gold standard for research ethics. That approach would have involved seeking a signed consent form from all members of the critical care group that were involved in this work, a form that fully explained the purpose, design, risks, requirements, and possible benefits to those involved. The reason informed consent was not sought for this retrospective study is because collecting it would have been impossible and/or impractical. Most of the staff I have worked with over the last fifteen years have since moved on to different medical departments, retired, or changed careers. This meant that there was no meaningful or fair way to have all potential participants (i.e., those who were present during my experiences) made aware of the information.

Instead, I have chosen to engage with this community to inform them collectively of the study, which means I have only collected general (or passive) consent. Given that this is a very large and transient group, I ensured that as many staff as possible were made aware of this research project by having the proposal distributed to each respective subgroup of critical care who were discussed in this project (i.e., physicians and nurses) and through word-of-mouth for allied caregivers working in the intensive care units (ICUs). Further to this, my research proposal was presented at research rounds, which are open to all critical care staff members and are recorded and can be viewed at any time. Lastly, the research proposal was submitted in writing to department heads for their respective review, for which I received (in writing) letters of support for this project from the Nursing Managers in Critical Care, the Director of Critical Care, and the Critical Care physician group.

Readers should know that all identifiers have been removed throughout this dissertation to protect the privacy of the individuals involved in these stories. Names, genders, titles, dates, etc. have all been removed and/or changed to prevent identification and no direct quotations are used. I have sought to maintain trust with the healthcare community that I am part of, which I deeply respect and honour. I also wish to uphold all community members' dignity and preserve their integrity. In addition, I acknowledge that the voices external to mine have been reinterpreted here, as they were only ever understood through my lens, meaning, I do not claim to represent the intentions or beliefs of others fully and accurately in this work. Instead, since I have spent many years discussing these topics with healthcare providers close to me, the goal is simply to tell my story, with hopes that it may reflect what others feel too.

The main risk to the study population (who are indirectly – hospital staff, and directly, me) is the discomfort that someone is likely to feel when engaging with the narrative describing these past events, which can bring up painful memories, disturbing imagery, or elicit distressing emotions such as sadness or grief, even anger. When reading the final product, staff may also disagree with my perspectives or how I have portrayed my understanding of their community, making them feel harmed socially or epistemically, or even that an injustice has been done to them morally. To avoid this, I have taken a great deal of care to become a trusted member of this community, to be fully transparent about my interest in reflecting on the issue of occupational stress in this setting, and I have attempted to present these stories with as much care as possible.

Many staff have also expressed to me over the years that they want to find solutions to help relieve the extreme stressors involved in their work and have been open to various efforts designed to address occupational stress, including being a part of research efforts. Further to this, when I presented my research ideas and my research proposal to ICU staff, I had very positive feedback. Many of them asked me if I would be interviewing them directly because this is something they wanted to participate in and know more about. I chose not to interview ICU staff because they had recently been interviewed by another ICU researcher, who then provided me with current data related to the direct experiences of our colleagues. Further to this, although direct 'member checking' was not conducted to validate my personal data, I have been told many times by staff that my words resonate with how they truly feel about their own work lives, and that my experience, in many ways, is a good representation of the challenges they face. This does not mean that the risk of misrepresentation is zero, but it is reassuring.

In this work, I will be disclosing the fact that critical care medical communities do suffer a great deal of burnout and moral distress, which has been recognised openly in both local and international research, meaning this is not secret information. Many physicians, nurses, and caregivers globally have published evidence to show how high the rates of burnout and moral distress are, and this information is already accessible to the public through major journals and platforms (e.g., the Canadian Journal of Anesthesia, the NIH, CMA, AMA). My analysis of this data may be well accepted by this community, or it may shock them, or they may simply disagree. These are all possible risks. The overarching goal is to avoid stigmatising this community and for the evidence of this research to only benefit them and never harm them.

Lastly, there are also risks to me as the author of this research. I have chosen to disclose a great deal of personal information in this project, including facts and events that were directly taken from my own life outside of healthcare (e.g., related to my health or illnesses as an adolescent), as well as my thoughts and feelings throughout my experiences within healthcare spaces (e.g., the emotions I experienced in stressful situations and the perspectives I developed as a person working in hospital). There was a minor risk of re-traumatisation by revisiting these experiences, however, I did not experience any harm conducting this work. While re-engaging with the data, I also attended therapy, prioritised personal self-reflection, and ensured that I was always acknowledging my feelings, accepting them, and validating my own experience. I had to engage in self-care while writing this dissertation, especially while working in the ICU.

I have used my best judgement to decide what I am comfortable sharing and have removed anything that I am not willing to share. I have also taken a lot of precautions to protect family members and friends. The main content that is not de-identified would be the information about my mother who is now deceased. I want to make it clear that I have no intention of tarnishing her name or shaming her actions, instead, my mother and I were very close before she died, and we would often talk about my bioethics work and she always said, “If you ever want to tell these stories someday, you have my permission.”

In this project, I use greyed-out boxes to signal to the reader that I am now telling a story, sharing a personal narrative, or recalling an experience from my past. These samples of text are taken from the data and are examples of a few of the salient experiences I had in the hospital. They are meant to operate as evidentiary support for the research, and they should help readers step into my position, mind, and perspective. Lastly, these stories take place over many years of my life and are not necessarily chronologically ordered, they take place not only in critical care (the last place I worked in the hospital) but also in my personal life outside of the hospital, in the operating rooms (which was my first job in the hospital), as well as in critical care – where the focus of this project lies.

Acknowledgements

I want to thank L'Aura – my closest friend – for showing me that I am deserving of love and care, for standing by me with compassion and acceptance when I experienced distress, and for helping me to see how I can better care for myself, and therefore, others around me.

I want to thank the hundreds of healthcare providers who took me under their wing and willingly and collectively taught me almost everything I know about the body, medicine, the hospital, and the politics of caregiving. I want to thank every caregiver who has ever shared their thoughts or feelings with me over the years, as these moments were the most significant. I adamantly hope that you all felt listened to and cared for.

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Chapter One

Introduction

This dissertation is a study of the physical, psychosocial, and emotional effects of stress on caregivers working in medicine, with a special focus on critical areas of care. In this project, I will present the primary reasons why critical care medical providers seem to suffer from high levels of distress and burnout, a major factor being due to the type of care that is needed/provided in this area, which often includes heroic or life-saving measures such as cardiopulmonary resuscitation (CPR), mechanical ventilation, massive blood transfusion, extensive invasive surgery (e.g. liver transplantation), or extracorporeal membrane oxygen therapy (ECMO).

Critical care is also one of the top medical specialities to suffer from what is referred to as *burnout* a psychosocial syndrome that affects energy levels, attitude, productivity, and mood in the workplace. Moss and colleagues (2016) describe how “up to 45% of critical care physicians reported symptoms of severe BOS” and “in paediatric critical care physicians, the prevalence of BOS is 71%, more than twice the rate in general paediatricians” (p. 108). Staff working in these areas, along with emergency providers, code teams, paramedics and others are highly likely to deal with trauma, death, and dying, but they are not always granted resources or time to process the emotions that come along with providing this type of care.

Although the main content of this research focuses on the years I spent working in a hospital, I begin by first providing a brief history of my own experiences outside of healthcare. A few of these stories relate to my struggles with health and wellness, and some of the others are meant to capture the moments when I entered the hospital for the first time. The personal information I weave throughout this project should help to set the stage for those reading this research project to be somewhat familiar with who I was before working in the healthcare system in Canada. This text should also help familiarise readers with my professional identity, which was moulded by my early life experiences, but was also moulded by my experiences within the medical institution itself. Most importantly, I have taken what I learned about self-care in life and have applied this knowledge to the stress of working in healthcare.

Chapter One outlines my experiences with my family as a young child, during my adolescence, and early adulthood; I explain my experiences with childhood trauma, neglect, and anxiety; I describe my first experience in the hospital where I witnessed a surgical procedure, and narrate some of the thoughts I had afterwards, which relay much of how I perceived the culture of medicine early on; I outline the purpose of this project, provide a summary of each chapter, and situate myself as the author and researcher; lastly, this chapter outlines the methodology used in this project, which includes the autoethnographic design, the methodological process I underwent (e.g., journalling, observing), and finally, how I collected my data, using retrospective observation, and how I analysed the data through a process referred to as thematic analysis.

1.1 My Experiences with Healthcare

I have always felt very strongly about 'wellness' in medicine, whether it be the wellness of patients or providers, and I have always desired to help make care delivery easier for everyone. This desire is what drew me to hospitals in the first place. I am not a physician or a nurse, I started my work in hospitals as a ward clerk learning how to coordinate resources in the operating rooms and later found myself working in the ICU as a research coordinator. In terms of my professional experiences – by being in hospitals daily, studying bioethics, and immersing myself deeply in healthcare literature – I have learned a lot about the realities of medical life. These experiences have opened my eyes and focused my interests, particularly on caregivers working in distressing situations. I strongly desired to help these individuals cope with the stressful and ever-changing conditions of their work in hospital environments. Working with these individuals daily helped me to see some of the flaws in the system, and our shared experiences brought to light critical aspects of caregiving that were being largely ignored.

One of the main things I noticed in the hospital was that despite the general outward acknowledgement that medical life is highly stressful and that distressing medical situations need to be handled with sensitivity and care, medical personnel still acted as though expressing emotion was dangerous, embarrassing, or shameful. When I asked caregivers why they were hesitant to express themselves I would get different responses. Some told me they believed that their emotions should remain private to uphold professionalism, others told me they were unaffected by stress, and some had no answer for me. Some caregivers would advocate for their feelings and openly express them, but these individuals were rare. I wondered, were these reactions individualised or was there a cultural milieu that also influenced people? As time went on, I noticed patterns, trends, and subtle messages that eventually became ingrained in my own way of being.

To meaningfully discuss topics like emotion, suffering, trauma, and abuse, it is necessary for me as the writer to share certain aspects of my own experiences with these phenomena with the reader. Given this fact, if the narrative throughout this project feels very intimate and personal, I want to acknowledge that it is. I have chosen to disclose these basic facts about my life for the reader to better understand my identity and where I am coming from. My epistemic position is inherently shaped by my relationships with myself and others (those who have shared their knowledge, wisdom, hopes, and fears with me over the years) and these experiences have made me "who I am." Carolyn Ellis, a forerunner in autoethnographic writing, comments on the personal nature of her work, and reveals some of the remarks made by those close to her about her storytelling:

> "Some friends and colleagues have reacted to the intimate quality of the text by asking why would I 'risk' divulging personal details about my life that show my flaws, disappointments, and bad decisions as well as my strengths, achievements, and good judgments. Although I appreciate the significance of these risks, I have not been swayed from my conviction that the sociological imagination can touch on the complexities, ironies, and ambiguities of living only by showing the bad as well as the good, what has been private and confidential as well as what is public and openly accessible, what makes us uncomfortable as well as what makes us comfortable" (Ellis, 1995, p. 3).

Undertaking this project has required me to take what I have learned not only from my family and close friends, or caregivers and medical staff, but also from what I have discovered deep within myself; that is, my knowledge of personal suffering, and later, learning to engage in self-care – such as properly identifying my feelings, compassionately accepting them, and gently dislodging the associated stress from my body.[1]

1.1.1 My Experience Outside of the Hospital

After my birth in a hospital (as a caesarean baby and fraternal twin) I was a person who existed mostly outside of hospital walls. I only visited a doctor, clinic, or hospital when I needed an annual check-up or for urgent care, and really for no other reason. I did not have friends or family who worked in medicine, I did not volunteer at hospitals, and I was never a sick child. I was quite healthy and strong in my pre-teen years and my parents mostly believed that you only go to the doctor "when it's *necessary.*" The few times I did need to visit a healthcare institution, for example, for a gash in my hand I sustained while biking down a steep hill, I was quite ignorant as to what I was walking into. I had no inside knowledge about the nature of what was happening behind the curtains, the doors, the wings, or the wards that had restricted access signs, nor would I have had any context with which to understand these things if I had been given a glimpse.

> As I sat on the blue leather stretcher in pain, I wondered what was going to happen next. My hand was throbbing, and the now-distant memory of being stuck in rush hour (on the way to emergency) would periodically flash in my head. I could see the vertical green posts of the bridge inch by the car window, and the red taillights made it seem like Christmas. I

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[1] For information on releasing stress from the body, Bessel Van Der Kolk (M.D.) writes about dealing with trauma that is held in the body in their book called "The Body Keeps the Score: Brain, mind, and body in the healing of trauma" (2014).

> could not see my injury due to the gauze that was loosely wrapped around my palm, and I wondered why I had driven my bike down that hill so carelessly. It was very steep and must have been almost a forty-five-degree angle. The goal was to ride my bike straight down the hill and turn quickly at the last second before I hit a pile of sharp rocks at the bottom. This plan worked in theory, and I succeeded until my last attempt. I could still feel the sharp rock that had broken my fall piercing my hand like a knife. I was thankful that it slowed my momentum, but that single sharp point was the only thing stopping the entirety of my body's weight from continuing forward.
>
> I sat on the metal table, in the white room, cold and waiting. Everything was mostly a blur, including the moments when I was being distracted by the doctor while they looked at my wound, or later when they pulled each stitch tight to close the skin. Soon, it was like no time had passed, the drugs were kicking in and the doctor was offering me a popsicle. I was delighted at first, then to my dismay, I watched as they handed half of it to my twin sister. “She isn’t sick,” I thought, “Why do I always have to share everything?” I sat waiting, not curious at all about what might be happening around me, either in the next room or even down the hall; instead, I simply felt an eerie sense of wanting to leave as soon as possible. After all, I didn’t know these people, and it smelled like cleaning chemicals. All I was left with was a deep ache in my right palm.

The only other time I remember going to the hospital as a young child was when I slipped on the carpet of the staircase in our family home and fell from the top to the bottom (where there was ceramic tile) knocking the wind out of me and significantly bruising my back and tailbone. My mother, in shock, instantly picked me up from the floor to hold me in her arms, and the paramedics later informed her that if I had sustained a spinal injury there was a risk of her paralysing me. Thankfully, I was fine, but my tailbone now sticks out a little more than other people.

Sadly, the period in my life where I would remain mostly illness and accident-free did not persist into my teenage years. After experiencing some turmoil around significant family relationships that were dissolving, I started becoming unwell. My sister and I had just started to feel the pressure of our adolescenthood and the hopes, expectations, and judgments of friends, family, and teachers. On top of this, one of our closest friends (we considered her our sister) stopped associating with us. We were unsure of how to process our feelings around this matter, and no one addressed it with us. The expectation was to move on, our friendship was *over* after all. I would later recognize the feeling as rejection mixed with grief, feelings that are not pleasant to experience, although they are normal. What is significant about this event for me was that it triggered feelings that were so strong that it felt as though there was no outlet for them, and with no help or guidance from our parents as to how to healthily process rejection and grief, I learned it was best to say nothing.

This experience alone was not enough to 'disorder' me, however it was a poor emotional foundation with which to start. Especially since it was only a few years later when my mother began saying things to indicate a rejection of my body (which felt like she was rejecting me). The most salient memory I have of this feeling, even though it had been building for years, was when I was hungry and went to make some food. I was always hungry, and I honestly don't think she fed us enough, and she told me to "stop eating at nighttime," or else I would "start getting fat." She looked directly at my hips and thighs and stared disapprovingly as she said, "I've noticed you started filling out," and went back to whatever she was doing. I thought to myself, "I am still growing right now…I am changing, but I never feel *fat.*" This judgement took only seconds for her to dispatch, yet it still settled deep inside of me. I questioned what was wrong with my actions and my body.

It was the first time I recall realising that being hungry was not enough of a reason to eat. This way of thinking confused me at first, but it seemed to be what my mother was telling me, that is, to stop listening to my body.[2] I started to pay more attention to mealtimes, to who was watching me when I opened the refrigerator or pantry, what facial expressions they had if I grabbed "unhealthy" snacks, or if the time of day seemed to be problematic (e.g., breakfast was always expected and met with approval, but eating shortly afterwards was frowned upon and judged). These concerns quickly became obsessions, ones that were important for me to master if I wanted my mother's approval and love. I had to learn what was 'okay' and what was not, since I never wanted to feel again how she made me feel that first night: disgusting and worthless.

After becoming more observant, I noticed how my mother would also comment on other people's bodies; it wasn't just me. The correlation seemed to be that thinner people were better and deserved automatic respect, and larger people were somehow less than, and therefore needed to be judged. To be charitable to her, she probably did not do this consciously, in fact, this behaviour seemed to me to be a bad habit, one that she did not even question. It was so ingrained that I later wondered if this way of thinking was taught to her by her mentors in life (e.g., her parents and abusive family members). Deep down I knew it was a sign that she was fearful, I could tell she was afraid of gaining weight and not being accepted herself, meaning, she did not want me to suffer the same consequences of gaining weight; however, I was not aware of all this at the time, instead, I simply believed her. I accepted that gaining weight would be a death sentence, a truly unlovable state that I should avoid at any cost.

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[2] This is an important point, as it is an example of how other people's beliefs, and their influence (or power) can alter the ways in which individuals perceive things. In other words, my mother literally taught me to stop listening to the natural rhythms of my body and my core physiology by telling me what I "should" be doing instead (i.e., how to eat, when to eat, what to eat, etc.). Her rationale was not based upon facts, instead, it was an emotional reaction, one rooted in her own fears and anxieties.

My mother also never directed this type of criticism or body shame towards my twin sister which often made me feel “less than” her. My sister was rarely hungry because she suffered from acid reflux as a child, and often had nausea and had to watch what she ate, so she remained quite thin as a teenager. If you are not a twin, I will mention here that (in my own experience) twins are constantly compared to one another. If one twin is different for any reason it becomes obvious to everyone what that difference is. For example, I was a very reserved quiet child, whereas my sister loved to talk and was quite loud and proud. The differences between us should have been accepted as normal and wonderfully diverse, but instead, the family would highlight these differences, even going as far as bullying me for not speaking up. By far the most damaging was my mother's constant judgments of my eating habits and slightly larger body which sent the subconscious message that being different was *not* okay.

At the age of fourteen, this distress developed into a full-blown eating disorder (anorexia nervosa) that eventually left me weighing only 89 pounds (at 5 '10''), having started to lose my hair, completely losing my menses and my sense of self. At first, my mother could not see what was happening to me, so she ignored it. But slowly she could see that I was avoiding meals and growing thinner. In one effort to gain back control, she would drag me out of my bed in the morning, strip me down, and weigh me in front of the family on a scale in the living room. If I had lost another pound, they would scold me and decide what I could eat that day. I recall opening the fridge to pour myself a glass of grapefruit juice and my father grabbed it out of my hands saying sternly “You can’t have that! It burns fat, you can’t fool us that easily.”

Once things got bad enough my mother pleaded with me to admit myself to the hospital for care, but I refused. Secretly, I was afraid of hospital care, but further to this, I was angry at her – I wanted her to see how her judgments had made me feel. “This is what you wanted…” I would tell her scathingly. But truthfully, my behaviour also gave me relief, it was a nervous reaction to the stress of my surroundings, and it gave me a sense of control and a morose sense of accomplishment. Even if everything else was falling down around me, my grades, my health, my relationship with my friends and family, I was succeeding exceptionally well at one thing: starving to death. Despite the degree of pride I took in succeeding at having an eating disorder, I also recall many moments where I was deeply afraid about what this was doing to my body.

> The whole tenth-grade class was focused on the global maps in front of us, each map designed to highlight the delineations between geographic locations. We were supposed to be memorising the countries for our final exam, but all I could notice was a heightened thumping in my chest. My palms were sweating, and my stomach kept making uncomfortable noises, declaring its emptiness to those around me. “Stop it!” I would mentally command my stomach, “Stop it, it’s embarrassing.” I hated how my body had a mind of its own. The teacher

> would glance at me as if to say, “What are you doing? Pay attention!” My breathing increased, and I could feel my heart racing and fighting. “Is this it?” I thought, “Will my heart just give out, right here, right now?” I did not much like the idea of my last moments being in a geography class, where everyone would notice that I was not strong enough to survive, that something was wrong with me. The words from my clinical psychologist bubbled up in my consciousness, “You can’t keep doing this to your body, you will eventually die if you keep this up.” Those words did not phase me, it sounded like a peaceful release. “I can do this,” I thought at that moment, “Just wait until it stops…everything will stop.”

Another time, I was shopping with my family and the effects of depriving my body finally became evident to me.

> I walked with my sister and mother through the hallways at the local mall; we were picking out new clothes for school. This was something our mother always did with us; she would buy us a new outfit for ‘back to school’ so that we could fit in. I noticed all the mannequins, how perfect they looked, their clothing draped just right. I envied them in their immutable form, cold and lifeless. I was nervous about how the clothes would fit on my own body. My stress was rising. I grabbed some black pants and went into the changing room alone. I deeply sighed and pulled them up around my waist only to discover that they were like clown pants – they were so baggy. I quickly investigated to find the tag on the back to determine what size this was, and to my initial excitement, it read “00.” “Double zero!! Wow!” I thought, I am so skinny, this is great. I walked out of the changing room feeling proud, showing my sister and mother how the double zero was falling off me. Then I saw their facial expressions of horror and sadness. It was then that I felt it too. “Am I disgusting to look at?” I thought, this cannot be normal… “Maybe it is finally time to stop all of this…could I even come back from this?”

I fought this battle for a long time, watching family and friends look on with confusion and fear. Many family members tried to pretend it wasn’t happening, but it was obvious, I was a skeleton who wouldn’t even eat a piece of her own birthday cake. Most days it seemed as though it was just me against my mother. She forced me to see a psychologist who specialised in treating eating disorders, see a nutritionist, and attend group therapy for girls who suffered from an eating disorder. Only when things got bad enough could I finally see how sick I had become, and at this point, I had grown a soft layer of velvety hair all around my body, which was trying to keep itself warm, my pelvis and ribcage protruded strongly outwards on either side of my body which was made more prominent by my stomach caving into itself, and my back was covered in bruises from constant exercise. I was frail and vulnerable to illness, and my temperament was that of a statue; listless and lethargic. If you are curious, I recently watched the 2017 film *To the Bone*, which I found to be a very accurate representation of my experience.

My mother was deeply worried about me, but she treated the situation more as an inconvenience to her own life, rather than as a dire need her child had to feel secure and safe. To her, it was all my fault, and I simply needed to "*stop it!*" It was a power struggle, where she was determined to make me eat, and I truly think she believed that if she could get me to eat everything would be solved. She never seemed to understand *why* I would act the way I did, and she clearly could not comprehend the degree of humiliation she was putting me through by her constant scrutiny and degradation of my body. She also had a complete lack of regard for my privacy and my autonomy as a growing child. When I started my period, I asked her not to tell anyone, since it was embarrassing to me, and I felt it was private. To my horror, she had told everyone in the family. When I asked her why she did that (because it upset me) she simply said, "I need to be able to talk to people about my life."

Aggravated, I would often close my bedroom door to be alone, or even to change my clothing after I had showered. She would always open my bedroom door without asking first, swinging the door wide while knocking on the side of the door as if to gesture that she *was* announcing her entrance, but really, she was forcing permission. My feelings were not important to my mother, and she was not interested in teaching my sister and me how to manage our emotions, because she honestly did not know how to do this herself. So, my sister and I did what we could to understand her reactions and cope. My sister would often get up in the middle of the night because she suffered from heartburn, so she would feel nauseous and go to the bathroom. This would alert my mother that one of us was "up," which made her angry, and she would simply tell her to go back to bed. Even if she cried from the pain, she was told to deal with it and stop keeping her awake. My sister does not talk about this often as an adult, but I know the lack of compassion and understanding that she received from our mother was difficult for her and made her feel unsupported. It also created anxiety in her, that if she were to feel sick, she knew no one was going to help her.

Returning to my own experience, eventually, my mother could see that I was suffering. My breathing was consistently laboured, I was so tired and almost delirious that I could not focus on anything, and I would move around often to relieve the pressure of my bones pressing down on the little skin and muscle that covered the bottom of my sit-bones – where I sat down. One day I could tell she was sad to see me like this, and she told me that she was *really* scared for me. I told her that I understood how scary it must be for her, and I thought about how I did not want to live like this anymore, but the disease had truly overcome my life.

One evening, as I sat on my bedroom floor, she came into my room to talk with me. I refused to look her in the eye, so I stared past her and out the window. She walked over to face me, crouched down and reached out to hold both of my hands in hers. As she held my hands, I finally looked up at her when she gently asked me, "Do you *really* want to die?" Hearing these words spoken so starkly, hearing the truth of what we had been ignoring for so long, broke down my defences. I sobbed. She said, "Because if that's what you truly want, I know I can't control you, it's your choice, but I love you and I am here to help you." She cried with me, as she gripped my hands tighter. The tears poured down my face and I could barely see her looking at me. I said, "No! Of *course* I don't want to die."

For the first time, her words felt compassionate, they were softly spoken, truthful, and kind. This shift could be felt by both of us because it was authentic, she was listening to me for the first time, and I could tell she had let go of the need to control what was happening. The fact that she was willing to let me decide, either to get better or to *end my own life*, was the ultimate demonstration of her empathy and compassion. This letting go was not because she didn't care, nor did she want my death to be the outcome; instead, she had finally accepted how I was feeling, even if the *truth* of how I felt was too hard for her to stomach, she accepted the reality of the situation. So it was at this moment that I knew she had accepted me entirely – because she no longer perceived me as a problem she needed to fix. She saw me as her daughter, whom she loved and wanted to help, but knew that it was my prerogative to decide how I wanted to proceed. I recognized at this moment that I did *not* want to stop living, I just simply couldn't go on living the way we had been. It was then time to make some serious changes, and I could tell that she was ready to lovingly help me.

By the age of nineteen, from all appearances I had gained enough weight to re-enter society as 'normal,' but my struggle with my own identity and with anxiety was not over. I was soon accepted to university and excitedly began my undergraduate education, since I always had a deep fascination with the human body, I chose to do a Bachelor of Science in Biology as a pre-medical degree. I had a natural aptitude for anatomy and physiology and felt that I might one day become a physician myself. I took every elective class I could find that was related to the body (e.g., human physiology, exercise physiology, human histology, parasitology, gross anatomy, neuroanatomy, hormones and behaviour, and even English literature on medicine and the body). These classes filled me with wonderment and joy, but I also had to fit them in and around my core classes of genetics, evolution, cell biology, ecology, diversity of life, and so forth.

Even though I liked medical stories, I was simultaneously intrigued by medical knowledge while also having some scepticism and fear. I loved staring at the jars of preserved body parts in the gross anatomy lab or seeing abnormal anatomy (e.g., a three-chambered heart), but I would still find them wrinkly and strange-looking. I would wonder uncomfortably whom the grey distorted tissue floating in a sea of formaldehyde used to belong to. One particular memory of mine encapsulates this feeling:

> It was the second term, and my physiology class was finally going to see the cadavers in the human physiology lab. I was excited and, of course, apprehensive. I grabbed my white lab

> coat and confidently walked into the room, deciding that I would be *fine* with whatever I was about to see. That was until I noticed the pieces of bodies that were displayed across tables around the room, having been severed from the individuals they once belonged to. I *expected* to see white blankets over bodies on metal tables, which were also there, but the specimens strewn about for us to touch surprised me. I was still composing myself, and keeping a safe distance from the specimens when my lab partner suddenly handed me something to hold… "Check it out!" She said with enthusiasm. I looked down and realised she was handing me a severed human arm, with the tissue and fat gone, the muscles preserved, and the bone showing. I could not speak right away, but I knew my facial expression read like a stern voice which said, "Please put that down…" She took it back and walked away. "Great," I thought, "Now it's time to see the dead bodies."

What I did not know at this time in my life – and what I would still not know until the age of thirty-four – is that I had a severe generalised anxiety disorder (GAD). After years of dealing with my mother, starving my body, and feeling helpless and alienated from my loved ones and myself, I was an extremely anxious person, always "waiting for the other shoe to drop." My early coping mechanisms – those that I first developed and used for self-protection – started to simply become an unconscious way of living my life. I had spent so much time in my youth learning to deny, repress, and control my feelings, as well as honing tendencies to withdraw from others, avoid conflict, and generally absorb judgments that were cast my way, I became utterly unaware of what I was feeling and what I needed. I had been conditioned to seek external approval for my behaviour (always looking to see whether my parents felt that what I was doing was acceptable, or not – a learned behaviour) and this prevented me from developing a strong inner sense of self-assurance and self-care.

1.1.2 No Sanctuary: Dealing with Trauma

When you are told your entire childhood that you are "too sensitive" or that you "shouldn't be bothered" by things, and even to "stop that," "do this," or "be different," it creates an internal narrative that something is always wrong with *you,* never the situation (Marici et al., 2023, p. 2). This type of what I will call 'easy-to-overlook' behaviour from seemingly 'good' parents was most damaging to me in vulnerable moments, such as when I was feeling sick or needed help. Instead of finding the comfort of a parent, I might be told "You're not sick, you don't look sick" or "buck up." In our household, it was never simply *okay* to feel how you felt. If those feelings were thought to be problematic or uncomfortable (e.g., anger, sadness, fear) my sister and I were expected to overcome these feelings – for reasons I am still not clear on today. At the time, we abided by this unspoken expectation to avoid punishment. Punishment was either dolled out overtly through yelling, swearing, scolding, or demeaning, and at other times we were met with silence, were ignored, dismissed, or felt abandoned.

This treatment was a form of conditioning[3], and it trained my sister and me to become accustomed to certain circumstances, which meant it was more likely that we would repeat behaviours that were rewarded (positively) and avoid behaviours that were met with punishment (or were negative). The problem with this type of conditioning is that it defaces autonomous freedom and teaches children to respond in structured ways. Rather than spontaneously explore and react authentically to their world, they quickly learn that there are ways they *should* and *shouldn't* act. This teaches children to hide their feelings from others, and sometimes even from themselves for fear of disappointing someone, losing a loving connection with important figures in their lives, or avoiding the internal pain associated with still having these feelings.

> "The literature on shame and guilt refers to these as 'self-conscious emotions.' Usually studied together, these emotions differ in how the self is evaluated. 'The experience of shame is directly about the self which is the focus of evaluation. In guilt, the self is not the central object of negative evaluation, but rather the thing done or undone is the focus. In guilt, the self is negatively evaluated in connection with something but is not itself the focus of the experience.' Shame, recognized as a negative emotion, involves an inferiority complex, powerlessness, self-consciousness, and a desire to hide flaws. Shame is often seen as a decreased need for affection from parents, as a tendency to be more egocentric, or as social avoidance" (Marici et al., 2023, p. 2-3).

The reason I say these emotions become hidden is because strong feelings like rage or grief do not simply go away because someone commanded that they do, instead, they remain concealed but still fueled, contributing to one's overall allostatic load. Guidi and colleagues define allostatic load as "the cumulative burden of chronic stress and life events" (2021, p. 11). A person may learn to cope with their inability to freely express their emotions by using strategies (e.g., distraction, withholding information) that help them to avoid the shameful feelings attached to the emotions, that is, from the harmful narrative that instilled the idea that having unpleasant emotions is "bad," and being quiet and obedient is "good." By obeying these emotional 'rules,' my sister and I further perpetuated my parent's

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[3] I am using the term "conditioning" loosely here, but I do mean to imply that the methodology employed by my parents was indeed, even if subconsciously executed, similar to what is known as operant or Skinnerian conditioning. "Operant behaviour, though defined by Skinner as behaviour 'controlled by its consequences' is in practice little different from what had previously been termed 'instrumental learning' and what most people would call habit. Any well-trained 'operant' is in effect a habit" and "a reinforcement schedule is any procedure that delivers a reinforcer to an organism according to some well-defined rule" (Staddon & Cerutti, 2003, p. 115).

abuse internally.[4] If children believe what their parents tell them, which is not out of the ordinary given the power imbalance between parents and their children, and internalise that showing emotion or asking for help (to deal with strong emotions) is challenging and painful (e.g., someone tells you that you're wrong about how you feel) or is something you will be punished for (e.g., you are scolded and sent to bed), then you learn that it is easier to pretend everything is fine and to deal with these things on one's own.

For this reason, I rarely knew *what* I was feeling as a teenager, *when* I felt it, or *why*. I became an expert at avoidance, people-pleasing, denial, and a form of self-abusive mental narrative that I used to reign in my natural inclinations (e.g., I would scold and punish myself, saying things like "stop that" or "what's wrong with you"). After enough time, these skills left me completely unable to access what was happening inside of me. I had sadly mastered the ability to feel the very beginning of an emotion and to instantly push it out of the way like it had never happened. The main sensation I could feel was the underlying sense of constant stress and worry. This made me hypervigilant, always paying attention to the moods and actions of others, and aware of my circumstances at all times for fear of impending danger. This also meant that I was being fake most of the time in public, never revealing how I truly felt, for example, asking for help or saying no. These were all signs of how significant my anxiety was becoming. Later in life, I would wonder why I was so sensitive, startled easily, or found loud noises terrifying, even though I was feeling overstimulated all the time.

The conditioning from my parents also meant I could not comfort myself or provide myself with compassion since this type of behaviour was never mentored or taught to me as a child. I never learned how to be kind to myself, instead, I *believed* that my actions were not proper, my feelings were wrong, and that I was deserving of punishment for acting badly. In their defence, my parents also never learned how to be compassionate, and they suffered more egregious abuse than I ever did (e.g., including physical and sexual assault). They witnessed things and were exposed to things that I cannot even comprehend, and in their generation, they were honestly doing the best parenting that they knew how to deliver. I do not place blame on them, it is simply a fact that one cannot mentor or teach behaviour that they do not understand or exhibit themselves, and this is the case for many people who grow up experiencing abuse.[5] This left me having not dealt with the many emotions I had experienced

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[4] The type of internal surveillance that I engaged in was not unlike what Foucault describes in his 1975 book "Discipline and Punish: The Birth of the Prison" where he discusses the type of control that is needed to contain criminals in a penitentiary system. I underwent physical and psychological punishment from my mother for any behaviours that were not deemed appropriate to her, and this was a way for her to exert power over me and gain control, which once internalised by me (as I learned the 'rules' of what was acceptable or not), my behaviours became habitual and were then self-monitored, whereby, that controlling force was then executed by me onto myself.

[5] An excellent initiative that demonstrates how abuse and traumatisation affect vulnerable people is Fritzi Horstman's YouTube video "Step Inside the Circle" and her creation of "the Compassion Trauma Circle" which is designed to give incarcerated men "a physical way to see and understand their childhood trauma by understanding the shame and

as a child onwards, meaning they remained undealt with and unresolved. My strategy as a young adult was always to carefully avoid as much stress as possible, and any stress that I could not avoid was deeply internalised.

During the first years of my undergraduate degree, a time of heightened stress, the need for control and safety emerged again, this time manifesting itself in a new way – as bulimia nervosa. It is a common occurrence for women who have previously suffered from anorexia to shift from one eating disorder to another, my therapist would later tell me. Before, after, and sometimes even during my classes, whenever I would feel unbearable stress, I would purge my food. This was very damaging for many reasons. First, I ate very little to begin with; second, this behaviour clouded my brain and strained my body making it almost impossible to focus and learn. I was also again damaging the tissues, cells, and organs of my body and completely disrupting my physiological homeostasis. Today I would consider my purging to be a type of safety behaviour[6] which allowed me to feel some sense of control in my life, but it did nothing to address my inner turmoil – it only temporarily relieved the anxiety.

This damaging behaviour would take five more years to overcome. When I finally stopped engaging in bulimic tendencies, I traded up again – this time, I found solace in rumination and overthinking. Every day I would wake up feeling anxious and worried, and I would then find ways to try to control my thoughts and feelings (i.e., repress and ignore them), or focus on improving my life (externally speaking, e.g., being good at my job). Despite these efforts, I was secretly awash with negative thoughts, fearful beliefs, and worries. I was constantly berating myself whenever I felt scared, hurt, or unhappy and continued to believe that there was something wrong with me. I refused to admit that anything had been wrong with my childhood, or that being surrounded by constant disease and death in the hospital was stressful for me. This would mean admitting that I could not handle my own life or the medical world.

I convinced myself that working in a hospital was easy, but I think the constant distress seemed normal to me. Even the periodic emotional abuse between healthcare workers seemed somewhat expected, and I accepted this way of life as 'just how it is.' I spent many years working in a hospital under the supposition that I was 'okay.' When patients came for surgery or to the ICU having experienced horrible or disfiguring accidents and traumas (e.g., having been pulled out from under a fork-lift that crushed their body, their arm only hanging on by a few tendons; having been hit by a

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dehumanization that results from both child abuse and incarceration." She writes that "these men found ways to make amends to themselves, to the people they'd harmed and to their communities" by acknowledging the abuse they suffered both in childhood, adolescence, young adulthood, and later in prison (Horstman, 2024).

[6] Safety behaviours, or what are known as "subtle avoidance," "involve behaviours which aim to reduce anxiety or prevent a feared outcome from occurring. In the long-term, however, these behaviours prevent the disconfirmation of threat because safety is incorrectly attributed to the safety behaviour, thus perpetuating anxiety. As a result, reducing or eliminating safety behaviours is an important target for many cognitive behaviourally oriented treatments (Sharpe et al., 2022, p. 1)."

train when crossing an intersection; or having tried to commit suicide only to shoot off most of their face while still surviving) I would start to feel the uncomfortable feelings of shock, horror, grief, and sadness; but I knew that showing these feelings openly would make me seem weak and unable to be in the world of medicine. So, I hid the way I felt (something I was already good at), engaged in awkward and often dark humour with colleagues, distracted myself, and *acted* like everything was fine.

Afterwards, I would go home and secretly wish that I had someone to talk with about what I saw that day, what the experience was like, how it felt, and what it smelled like; but no one *really* ever understood. Often, people would not even want to hear about such things, they would make an awful face of disgust and simply say "I don't want to hear about that" or "I don't want to think about that." I could always rely on my co-workers to understand, but they were seemingly trying to deal with and process these experiences too. We were all somewhat "in the same boat." Dealing with my own stress in the hospital became even more difficult for me when I started working in the ICU, since the frequency of sad and futile cases was constant and unrelenting, rarely showing a break from the monotony of death and dying. The staff were also hardened and were less interested in coddling anyone. The culture seemed to be "either you can handle it, or you can't," something I had trouble with during the Covid-19[7] pandemic when I would mostly only see members of the ICU team for years, since social gatherings were infrequent or discouraged, and I still had to work in this setting in person every day.

After reaching a critical breaking point, which came after working almost seven days a week for four years in the ICU, I pondered very seriously why I could not seem to feel content. I was still convinced that I had to get my feelings under control or change the way I was, neither of which was working. I had not yet accepted that I had experienced anything but a 'normal' childhood. I was still engaging in self-abuse (i.e., ignoring my feelings and criticizing myself), struggling internally, and telling myself lies, all the while finding distraction in my work during the day (in the hospital and elsewhere) and comfort from watching mindless television shows to distract me at nighttime. What I would later finally acknowledge is that I *had* experienced some trauma in my youth and that it was *okay*. Even though I had adopted many unhelpful personal strategies for dealing with my emotions and stress (which affected my mental health) and I had not sought help or found support for any of this suffering, I could still be helped.

It took four years of working in the ICU before I began to discover the truth about myself, that is, I was recovering from years of trauma as a child, and I was now piling more traumatic events from the hospital on top of this allostatic load. My awareness around this seemed to happen somewhat gradually, and then suddenly it became clear to me. Certain events would grab my attention and alert

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[7] The Covid-19 pandemic refers to "The coronavirus disease 2019 pandemic" which was "a global outbreak of coronavirus – an infectious disease caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)" (WHO, n.d.).

me to the fact that I was reacting extremely adversely to a scenario that should be manageable, giving me pause to stop and question *why* I might react that way. One day, a family friend mentioned to me, during a particularly difficult period, that it was *okay* to feel how I did. This took me by surprise since it was a thought process that had never occurred to me, but I was suddenly aware when I heard it. I wondered if maybe it *was* okay to feel how I was feeling. I decided to call my family doctor and ask about mental health screening, a phone call that first took overcoming *a lot* of personal fear and shame around the possibility of a diagnosis.

I mustered the courage to call because I knew that I no longer wanted to feel this badly, and my family doctor happily agreed to screen me. It was quick and easy, and afterwards, she told me that I scored so highly on anxiety that she recommended I see a psychologist or counsellor to help ease the degree of distress I was feeling. She seemed surprised that I was still working and going to school, holding together a seemingly average lifestyle. She said that she felt it would make me feel a lot better. I agreed to see someone and spent the next year uncovering what had happened to me, slowly learning how I had ignored the deeply held stress I felt in childhood, adolescence, and early adulthood (a period when my mother also suffered from breast cancer and eventually died), the harm this caused me, and lastly, the types of coping strategies I was using to protect myself. This psychologist also said that it wasn't my fault (a concept that also took some getting used to!).

I also wanted a diagnosis,[8] so I sought one from a psychologist and a psychiatrist. The psychologist diagnosed me as having a very significant generalised anxiety disorder (GAD), and a colleague of hers explained to me that I probably have "complex" PTSD from my experiences in childhood. The psychiatrist said that I did suffer from classic traits of PTSD and further confirmed that I had extreme anxiety, all due to trauma experienced in my childhood (from mental, emotional, and physical abuse). The Cleveland Clinic writes that "complex post-traumatic stress disorder (CPTSD, C-PTSD or cPTSD) is a mental health condition that can develop if you experience chronic (long-term) trauma. It involves stress responses such as anxiety, flashbacks, or nightmares, avoiding situations, places and other things related to the traumatic event, heightened emotional responses, and persistent difficulties in sustaining relationships" (2023). Trauma that induces PTSD in individuals

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[8] Receiving a proper diagnosis from a healthcare professional (such as what might be defined in the DSM-V for mental health) has both benefits and drawbacks for patients. First off, it can be difficult to seek treatment or be prescribed medications if one has not been officially diagnosed as having a condition, e.g., the use of sertraline or Zoloft® is mainly prescribed for obsessive-compulsive disorder (OCD) or major depressive disorder. Secondly, an official diagnosis can also help patients to better understand what they are dealing with and can better guide treatment plans overall. Some drawbacks may include the stigmatising effect of being labelled with diagnoses that are misunderstood or have fear associated with them, such as schizophrenia or bipolar disorder; as well, diagnoses are categories with highly specific criteria, symptomatology, and treatment regimes, all of which may be limiting for treating the more diverse expressions of the disease in patients, especially if a person does not fully fit the criteria, or only partially meets the criteria for official diagnosis.

will even cause physical changes in a person's brain, which will further change the way the body both perceives and handles stress (Leblanc, 2020, p. 78-79).

This was all true for me, and once I knew what I was dealing with I decided that it was finally time to give myself the acceptance and care that I needed. This statement makes it all look very easy and straightforward, but on the contrary, it took more than two years to begin to comprehend the idea that it was *okay* to feel emotion, and further okay to *accept* how I was feeling without judging myself (even if the emotion was thought to be bad or ugly). When someone truly believes that it’s not acceptable to feel a certain way, a good example is jealousy, they will often take measures to avoid admitting the truth of how they feel, especially if it is something that feels condemning to the self. Consider that “jealousy has a negative connotation in Western culture and is often looked upon as a socially undesirable emotion” and that “most empirical studies also have found that lay people tend to define jealousy in mostly negative terms” (Attridge, 2013, p. 2). Since jealousy is thought of as negative, it can feel harmful to the self to admit such a negative quality could be true about oneself. However, continuing to feel an emotion while simultaneously denying its presence is far more damaging in the long run, since it becomes impossible to face and overcome that feeling. It was very hard for me to admit how I was feeling.

Once I began to master techniques that supported me to enhance my self-care daily, I began feeling so much better, which was a relief. Further to this, I was then able to start applying this tacit knowledge to the subject of occupational stress. In other words, I would apply the same tactics I had learned to address my childhood trauma at home to the trauma I felt I was being exposed to at work (in the hospital). When I felt sad that a patient had died, upset after the team had to do aggressive CPR, or uncomfortable saying pleasantries to the family whose loved one had just been declared brain dead, I would allow myself to feel how I felt without judgement. I would accept how I felt and then try different methods of comforting myself amid distressing situations, whether that meant walking away, breathing deeply, and/or telling myself “It’s okay, you are safe.” These small changes made me feel liberated, and it made working in the hospital much more tolerable; although importantly, I still did not disclose my feelings to others in the workplace, because I could see that openly expressing emotion was simply not part of the culture.

1.1.3 Initiation to the Hospital: Patient Zero

Long before I had this realization, that I could compassionately accept my emotions and comfort myself, my first serious impression of hospital care, which ended up being quite formative and consequential for me, took place when I was a pre-medical student in my undergraduate degree. It took place in an operating theatre that seemed no different than all the others. The walls were white, there was one metal table, and the lights were bright. This theatre was, however, specialised. It was where ‘general’ surgery would take place, a term used to describe intra-abdominal surgeries centred around the stomach, appendix, gallbladder, bowels, colon, and so forth. This was the first surgical suite I had ever been in, and it was where I would first excitedly donn'[9] scrubs, a gown, a surgical cap, a mask, and foot covers.

These garments were new to me, most of them disposable, but the scrubs or "greens," as my friend still called them (a bit of a misnomer now, since our scrubs used to be green but are now blue) were thin and worn, having been through countless surgeries themselves. There were faded pen marks on the pants, surely evidence of another surgery, what looked like "metfor., no MH, NPO, Hx ETOH," abbreviations that meant little to me at the time. I wore this uniform because I had to, but it also helped me look the part, which I liked. Mostly, these garments were cleaned by hospital standards which was thought to help protect both me and the patient. Sadly, these threadbare cloths could only help to ward against corporeal threats like blood splatter or perhaps some bacterial infections. They could not protect me from what I would see or feel.

Figure 1: *Gowned and Gloved*, Oil on Canvas, Painting by Joe Wilder, MD, Director of Emergency Services Mt Sinai Hospital New York (Wilder, n.d.).

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[9] Donning and doffing are terms that refer to safely putting on and taking off personal protective gear/equipment in hospitals. Donning includes activities such as washing hands, and putting on gowns, masks, and gloves properly, whereas doffing requires careful attention to be paid to taking off soiled or infectious clothing without touching it or spreading microorganisms and bacteria. This is achieved by sequencing the taking off of all equipment (taken from Baystate Health's Society of Thoracic Surgeons webpage: https://www.sts.org/sites/default/files/Donning%20Doffing%20(2).pdf).

The surgical team rushed around the room in preparation for the emergency case. As they hastily prepared for the patient's arrival, displaying tools, prepping drapes, drawing drugs, and counting sponges, I stood quite still, trying to avoid contaminating the surgical field or revealing my novice nature.

The operating room was foreign to me, and I did not belong there for any reason other than for the facilitation of my medical gaze. I wanted to "see," I told them I wanted to "see what it is really like." I was an outsider, a lay person, who was finally standing inside, inside a space where few got to be onlookers. Because of my privilege, as a student at a renowned university where I studied to prepare to work in the medical field one day, I was allowed to see these private moments, where any patient needing surgery on that day was thought to have generally consented to my presence – though they were likely not aware of it.[10]

I stood beside the empty metal table and felt the wonder and excitement inside of me. I thought, "What will I see? When will they arrive? What type of case is it?" The surgeon then asked, "Have you eaten breakfast? Because it's a good idea to have food in your stomach." I nodded in agreement, even though I was lying. I thought, "Who can eat before 6:00 am?" Finally, the patient arrived. What looked only to be a white sheet rolled through the double-blue doors. My eyes were unblinking as I searched the patient's bed, but all I could see was the rounded mound of an abdomen, one so large that it obfuscated any sense of its attachment to a human body. The team got to work. The blankets were torn off, exposing legs, feet, and toes. I finally could see the shape of the patient before the blue surgical drapes covered everything that was not the surgical site.

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[10] Patients undergoing specific surgeries are anaesthetised under general anaesthetics (or drugs) that put them to sleep, meaning student observers can watch these operations without the patient knowing that they are there. The surgical team can choose to introduce observers to the patients prior to beginning their surgery, or ask them whether or not it is okay if someone watches, but this is not always practised. From my experience, patients also seem to assume that everyone who is in their operating theatre is there for a good reason. This practice is not in line with the principle of autonomy nor does it respect the patient's right to informed consent, but as a note here, it does happen.

Figure 2: *The Surgeon Placing Sutures*, Painting by Joe Wilder, MD, Director of Emergency Services Mt Sinai Hospital New York (Wilder, n.d.).

> I wanted to get closer, but I also wanted to respect both the surgeon's space and the patient's dignity, so I stood back. The nurse leaned over to whisper in my ear "This patient has nec-fasc." I thought – what does that mean? I wondered, is it a virus, a parasite, or what? I began to worry about whether I could *catch* this mysterious infliction. She then explained that this would require the "Scrubbing of skin off the body to slow the infection." I could feel the acid growing in my stomach. I wondered, "Do surgeons *really* do this to people's bodies?" "Are there diseases that require our skin to be scrubbed off?" I felt shocked. It took the team only minutes to transform this patient's abdomen from white to beige, to brown and dripping with povidone iodine. The surgeon was standing steady with their scalpel poised just above the integumentary barrier when I thought, "What courage it must take to plunge the blade through the layers of skin, fat, and muscle…" This was a person after all. Time seemed to stop as I stared at the knife over the belly.
>
> I was filled with a deep sense of impending danger and fear. I wanted nothing more than to protect this patient from what felt like it would be an assault on their body. I thought, "Maybe he doesn't have this nec-fasc," "What if they are wrong," "Did anyone double-check to be sure?" I wondered, "Is there any way to avoid cutting this person open?" It all felt so fast, and the idea of opening someone's abdomen was foreign to me. The general anaesthesia had just barely taken effect and the patient was now at the team's mercy. The surgeon cut with

> more confidence than I could have ever imagined. It was like they were drawing a line from the breast to the pubis with a marker, with each swipe – or slice – through what could have been butter, more and more of the belly loosened and opened for all to see. Pink, red, and brown, everything inside was swollen and coiled. The residents struggled to retract the layers of fat until the viscera became the only field of sight.
>
> The surgeon then grasped the patient's now resected colon in two hands and began to squeeze as if they were trying to empty a sausage casing. The nurse leaned over to me to whisper, "Now they are going to squeeze the shit out." "What?" I replied sharply. My hand independently grabbed the shoulder of a nearby medical student just in time, as my knees weakened, and my stomach churned. I could not believe what I was seeing, and I had no context with which to understand it. Then it hit me, the stench and the burning smell of cauterised flesh combined with faeces. I worried that I might be sick, or faint, just as the surgeon said to me, "The smell can make it a lot more difficult." A senior nurse then walked in behind me, saw my expression, and slapped me (quite hard) on the back while rhetorically asking, "Can't handle it honey?" As they let out a menacing laugh. I knew I needed to get out of there.
>
> I quickly exited the operating room alone, mid-surgery, looking for a place of comfort, anything that might resemble the world I knew before this scene. I found the nurse's changing room which was (thankfully) empty. Everyone was in surgery, I thought. I laid down on a long wooden bench between the rows of lockers where I could see the upside-down pictures of healthcare workers' families and magnets with catchy phrases like, "Have you hugged your anaesthesia tech today?" My heart was pounding, my breath rapid, and my palms sweaty. I felt disembodied and quite vulnerable. I thought, "They seem to be able to handle it… why can't I?" I was simultaneously sad for the patient and their tragic circumstance, and confused as to how the healthcare providers were "fine." I wondered how the nurses and doctors could come to find this normal. No one appeared to be afraid, feel sick to their stomach, or were even perturbed by the awful smells and invasive measures. I felt like an alien.
>
> While on the bench, my mind reasoned obsessively, producing thoughts like "I am fine," or "I simply need to compose myself," and even, "I can do this."

At this time, I could not accept that I needed to process (or, ironically, digest) what I had just witnessed. It was not an option (in my mind) to accept that this event was simply awful or to admit that "Of course, I would be scared" since this was the first time I had seen a human being in such distress, the first time I had looked inside a living human, and the first time I learned of such a threatening illness. No part of me thought silently, "It is *reasonable* to feel this way." Instead, my lifetime of conditioning (i.e. the way I was raised), as well as how I had just observed real healthcare workers acting, took over. I was determined to overcome these feelings and to instead "be strong" and learn how to ignore my reactions, especially if I wanted to work in medicine one day. I knew I would need to overcome the sight of guts, I would need to endure wretched smells, I would have to find a way to stifle my emotions towards patients, and overall, I would have to strive towards resilience or imperturbability.[11] Most importantly, to fit in I would have to hide my true feelings from others, to avoid seeming *different* from them, and to avoid being ostracised or judged.

> As these thoughts passed through me, I gazed at the fluorescent lighting and asked myself nervously, "Can I ever come back here?"

Figure 3: Surgical Table in the Operating Room, Photographed at Work, Unknown Date.

I would later learn that this patient had necrotizing fasciitis (NF) or what is sometimes referred to as "flesh-eating bacteria" or "flesh-eating disease," and that I was having a trauma response. With NF, nothing is truly eating the person's flesh, instead, bacteria invade the wound area (often group A streptococcus) and create the rapid spread of toxins from cellular waste and lyses that, in turn, restrict blood flow and oxygen to localised tissues, causing them to die or become necrotic (Wallace & Perera, 2023). This patient suffered from Fournier's gangrene – named after Dr. Alfred Fournier who first

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[11] The term "imperturbability" has been famously used by William Osler, as Jones (2019) writes "Sir William Osler delivered his famous Aequanimitas address in 1889 wherein he stated, 'In the physician or surgeon, no quality takes rank with imperturbability.' He implored the graduates to have 'coolness of mind under all circumstances.' Aequanimitas is the term physician's use for imperturbability in the culture of medicine, but the value of imperturbability is well known in ancient wisdom and extends across most cultures" (p. 2901).

described this phenomenon in five of his patients in 1883 – which presents specifically in the scrotal and perineal area of the body (Leslie, Rad, & Foreman, 2022). This affliction requires immediate medical attention in the form of mixed antibiotics and surgical debridement of the infected tissues. In this case, the infection had spread up the patient's anterior abdominal wall, requiring the general surgeon to do a laparotomy (or to open the abdomen) to investigate, clean the area, and do a bowel resection.

I do not know if this patient ended up living or dying, but I do know that I will *always* remember this case. This was not only my first experience standing at the bedside of another patient in the hospital, but it was also the first surgery I had ever witnessed. My opinion at the time was that watching a patient be cut open was the height of medicine, the most exciting – yet invasive – way to receive care. If I were to compare this case to the experiences I had before being in an operating suite, such as having an annual checkup at my family doctor's office or the occasional blood tests, x-rays and such. This case was the epitome of going from zero to one hundred. It was mental and emotional whiplash. I spent a long time considering how this case made me feel. Yet, despite the years it took me to understand this experience, it was only a month later that I would apply to work in the operating rooms, and subsequently, spend the next fifteen years getting to know this surgical environment more intimately.

Throughout the years, some surgical cases would bring me excitement and wonder (e.g., hand re-implantation surgery) from which I would learn a great deal about the body and medicine, whereas others created a feeling of fear or horror (e.g., a patient who cut off their ears to stop from hearing voices, or a young patient who had their leg torn off in the mechanics of a fishing boat) spurring on a reactionary need for dissociation or numbness, eventually leading to an overall sense of apathy or being "fine." Even though I was used to denying my emotions, the operating room has a way of strongly bringing up even the most hidden feelings. Tentatively, one case after another, I forced myself to become accustomed to this sterile yet blood-soaked environment. Each time I acclimatised a little more, I felt my emotions wane, as they began taking a backseat to my intellect. I would force myself to explore my surroundings, I would ask to watch surgeries or shadow organ donations or tissue retrievals, and in general, I would learn from staff members. Eventually, things seemed to become easier, even routine or expected, helping me to feel a sense of comfort in the OR.

Years later, I would not find the NF case distressing at all. In fact, I would find it commonplace, perhaps even boring. Since then, I have probably noticed fifty or more cases of necrotizing fasciitis go through the OR over the years. This change of heart, or what felt like an inevitable and slow change in my identity through a progressive process of changing my opinions, thoughts, feelings, and thus perspective over the years, was just a matter of adopting better coping strategies to deal with the realities of medical care. Part of me was indeed adapting and becoming familiar with my surroundings (i.e., becoming *used* to everything), and another part of me was denying my more automatic feelings. I would see something awful and pride myself on being up to the task, able to work around the patient's misfortune and suffering without flinching. But there were still feelings there, feelings of discomfort, upset, and fear, they were simply hidden more expertly.

I believe most if not all healthcare providers have an initiation like this one, similar to the necrotizing fasciitis case, although every initiation will be unique, and it may not happen on the first day. From my experience, a sense of true initiation in a hospital is usually defined by a particularly memorable experience, whether it is good or bad. For some, it may be the first time they intubate a patient successfully in the ED, for others, it may be marked by the first meaningful conversation they have with a patient. It may even be after the first death of a patient. In my case, the experience of NF left a somewhat negative impression on me, which other healthcare providers that I work with have sympathised with.

One ICU nurse recalls being forever changed by the first time they saw a burr-hole (the drilling of a hole into the patient's skull by a neurosurgeon) being done at the bedside in the ICU. I recall them reflecting on how they would not be the same person they were before witnessing that incident. In another example, a medical student once confided in me that she just about fainted when a surgeon debrided the skin off a plastic surgery patient's body whose wound sloughed off and "looked like pudding." Importantly, there seems to be something that happens in the space between one's first true initiation in the hospital, and everything that occurs after that, all of which seems to progressively help shape the professional identity of a caregiver. We will discuss this topic further in Chapter 4, which explores the concepts of personal and professional identity.

The literature is filled with stories from medical students, residents, doctors and nurses (to name a few) recounting their slow adaptation to living a life of medicine, which often includes an initiation to patient bodies (e.g., cadavers and dissection), an initiation to learning medical knowledge (e.g., classes and examinations) and its associated responsibilities, an initiation to clinic work and hospitals (e.g., learning how to navigate the hospital, its technology and culture) and lastly, an initiation to patient care (e.g., exposure to illness, injury, death, and dying). Zoltán Zsinkó-Szabó of Semmelweis University, a physician of Mental Health Sciences in Budapest, Hungary writes that:

> "This initiation is not a one-time event, but a process of many initiation-type components built upon each other. Most of the initiation processes of becoming a doctor are *hidden*, and barely conscious, unlike sacral initiation rites. This initiation process is a transition as well, thus corresponds to the model of the rite of passage known from anthropology. In the process of becoming a doctor initiators and initiating communities may have an important role, in the medical – and in a wider sense – healing subculture. In the process of becoming a doctor, the following occurrences may have an initiatory role: encountering the body, disease and death, stress during training and a variety of symbols. Also, here we can mention role models – occurring in personal interactions or in the media – providing positive and

> negative examples and education of medical anthropology designed to ensure a wider attitude of approach" (Zsinkó-Szabó, 2014, p. 12, my emphasis).

My initiation is unique and personal, and I share it here in hopes that others may identify with these feelings, having also felt the same way during their initiation (e.g., anger, sadness, grief, frustration, even sickness or horror). My ideas around 'distress' in the medical world have been ever generating, entangling, and adapting to the changes in my personality and life for a long time.

1.1.4 My Time Spent Working in Hospital

I have worked in multiple hospitals for over fourteen years, dividing my time between discrete departments, clinics, and units. I was first hired in a perioperative department (the operating rooms) in 2009 as a unit clerk[12] where I was tasked with helping the 'charge' nurse (as they are called, or the head nurse) to coordinate all surgical services for the day. This included supporting, coordinating, and facilitating the needs of many operating theatres, surgeons, anesthesiologists, OR nurses, sterile processing staff and equipment, patient attendants, and the patients waiting for surgery.

Figure 4: Working in the Operating Rooms, Self Portrait (2018).

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[12] According to the hospital's job description for the unit clerk or "Ward Clerk," this role "is the initial contact for the unit and ensures clear, concise communication and facilitates the flow of information with other facilities, the health care team, visitors, family members and patients" (NSH).

My day always began in the middle of the operating rooms, or the centre core as we called it, where I would review the elective and wait-list surgeries planned for the day. Once I had oriented myself to the plan for all nineteen surgical suites, I then went about ensuring that the patients had arrived, that each OR suite had a case cart (or surgical equipment) ordered and that it was outside the OR door, as well as coordinating with the nurses and physicians to manage their surgical day by making phone calls, booking new cases, communicating emergencies, and determining the bed management plans with the nursing floors, the recovery room, the charge nurse, anaesthesia, and the surgeons. Many days were run-of-the-mill, managing cholecystectomy patients and hip replacements; however, there were often emergency cases in the evenings, when we would prepare for unplanned cases like ectopic pregnancies, burns, or ruptured aortic aneurysms.

In 2012, I was asked to work in a therapeutic abortion clinic to cover a one-year maternity leave. This department was locked down and secure, located in a secret part of the hospital, and unmarked. My interview for this job was careful and deliberate, since the team needed to determine my perspective towards the issue of abortion; they wanted to ensure that I would not be judgemental and that I would strictly maintain the confidence of all patients needing to receive care in this unit. I was a clerk for this unit, preparing paperwork, ultrasounds, and patient bookings for women and girls who accessed the clinic. I worked closely with the charge nurse and three physicians who ran our operations. During this same year, I began wondering what type of career I might have someday, so I began to study tissue retrieval. I had seen this work in the OR having shadowed the staff, and I later applied to work with them. This would have been a career of recovering tissue, bone, muscle, and so forth. from cadavers to process and store for transplantation, but the position went to someone else, and I moved on.

In 2013, I was asked to replace a staff member who was going on leave, so I spent a year working on an orthopaedic post-operative inpatient floor, helping the charge nurse coordinate care for those patients. Inpatient care can be hectic and overwhelming in an entirely different way than working in the OR. Operating rooms are highly structured and managed, and despite the number of patients, the emergencies, and the big egos, the stress of the OR would oscillate, transitioning from highly stressful for a few hours, to relatively quiet, then back to feeling stressed. An inpatient unit is constantly chaotic, with multiple patients in each room, numerous medical services all descending upon the same small area (the main desk), as well as family, housekeeping, nutritional services (those delivering food), blood services, x-ray techs, residents, and medical students, all wanting their questions answered and their patients' needs addressed.

My responsibility was to manage the intake and discharge of all patients on the unit, including those coming from surgery and those leaving the hospital. This inpatient unit strictly serviced and cared for patients who had orthopaedic needs, including any procedure, treatment, or disease/condition of the musculoskeletal system that affects your bones, muscles, and joints. I managed the daily operations of paperwork, clinic appointments, patient diets, timing of bodily scans, and the coming and going of family and friends, as well as monitoring the designation of hospital beds. When the year ended, they asked if I would like to stay full-time, but I declined, given that my stress levels had become far too high in that environment. The best way I can describe this position is to ask you to imagine sitting in the middle of a frenzy of multiple nurses, all of whom are running around, talking over each other, and explaining why they do not have time to answer your questions. The phone is ringing off the hook and patient buzzers are going off, while the resident is asking you to call x-ray. You are responsible for all of these tasks, and they all need to happen *now* – even though you have a mind-numbing headache.

In 2014, I interviewed for an administrative assistant role in the department of critical care medicine. I was offered and accepted this job, which was to support two Health Service Managers (HSMs) and their respective units (two intensive care units (ICUs) and an intermediate care unit (IMCU)). I was responsible for coordinating staffing, managing the schedules of the HSMs, assisting with interviewing and hiring, organising meetings and taking minutes, collecting departmental statistics, and distributing resources (e.g., ordering new chairs, providing stationary, making emergency phone lists, designing booklets of medical guidelines, and processing files). I was simultaneously a clerk for the Smoking Cessation Program run through the Heart and Stroke Foundation, which required me to check in with patients (over the telephone) who were enrolled in the program due to their smoking habits. I would ask them about their success and struggles with the cessation of their smoking habits after being discharged from the hospital – all of whom had undergone a procedure or treatment in hospital and were referred to the program.

During these concurring administrative roles, I would do this desk job during the day, and then act as the unit clerk for the operating rooms or recovery rooms in my spare time in the evenings. I loved the front-line staff who worked in these departments and truly enjoyed working with them. I also missed the more patient-facing roles and “front-line” work which I found very exciting. In retrospect, as much as my administrative position was less exciting to me at the time, it did help me to understand the more corporate side of healthcare and how managers choose to run their medical units. Further to this, as an aspiring bioethics student (still pursuing my undergraduate studies) I shadowed and learned from the multi-organ transplant (donor) team, chronic pain staff, anaesthesia and surgeons, medical residents, and intensivists. I worked with and sat on committees such as the clinical research ethics board (REB), the children's hospital program Self-Help Connection that supported girls with eating disorders and sat in as an observer for Francois Baylis’ Novel Tech Ethics (now called Impact Ethics) group (Impact Ethics, 2024).

In 2015, I left my administrative role and went away to another province to complete my Master’s degree in Health Ethics. In this program, I studied ethical foundations, the history of bioethics, ethical dilemmas, and the literature surrounding the ethical nature of medical delivery and care, where I learned how to apply this knowledge in the field. Within this degree, I completed a practicum (hours of front-line ethics work) where I was further immersed in hospital environments, attended ethics consultations, and ethics meetings, and was a student member of both the clinical and non-clinical research ethics boards. This experience and education provided me with the foundational knowledge required to work in bioethics as a professional, and it provided me with most of the necessary tools to practice. However, rather than apply to be accepted into a clinical ethics fellowship (a further credential that is often required to practise clinical bioethics) I came back to my home province.

When I returned home in 2018, I applied to work as the administrative assistant to perioperative services, which was the same job I had in 2015 for critical care, except this time my work was being conducted in the operating rooms, recovery rooms, and day surgery clinics (instead of the ICU & IMCU). I also applied to the interdisciplinary PhD program at my local university. I was accepted for both, and I simultaneously worked full-time at the hospital and completed my coursework and exams for my degree, while planning the general direction that my doctoral research would take.

As a graduate of health ethics, I also joined an ethics education committee, an organisational ethics committee, and a steering committee revolving around understanding paediatric death. I also collaborated with my local bioethics department to assist with ethics education sessions in the ICUs on moral distress and burnout. Despite all my experiences to date, I still wanted to learn as much as I could about medicine, which led me to continue learning about topics such as end-of-life care, shared-decision making, palliation, trauma care, and the process for responding to 'codes'. It was also not uncommon for staff to discuss patient matters, ethical dilemmas, and decision-making difficulties during the workday, as these are a prominent part of working in a hospital.

In 2019 I was asked to work in the ICU, a job that would take me between different hospitals and units to collect research data. This job offer came at the same time I was beginning to settle on 'burnout' – as experienced by healthcare professionals – as a topic of interest for my doctoral work. I had become very comfortable working in the ORs, and my administrative role was not intellectually challenging enough for me, so I did feel I needed a change professionally speaking. I also required a job that would allow me to have flexible hours so that I could study in my spare time, so I accepted. Little did I know, ICU is among one of the top areas of medicine to suffer from burnout, which in retrospect, made this a good opportunity to be exposed to more end-of-life care and difficult conversations in healthcare. I would be paid for my work in the ICU (which allowed me to pay my rent and tuition), and I would also have a chance to learn about a different area of care, their patient population, and the type of work involved with delivering critical care medicine.

My role in the ICU was to participate in what is called the "ICU database" (a research program) under the supervision of one of the ICU intensivists who had created a digital database to better track both the epidemiological and medical statistics of patients. Each day I was expected to collect information at the bedside on all admissions to the ICU, create an APACHE score (Acute Physiology, Age, and Chronic Health Evaluation) or illness severity measure through compiling patient labs, vitals, their diagnosis, mobility scores, treatments, etc., and track their daily care during their stay. Some of the primary statistics captured daily would involve recording the patient's CAM (or confusion assessment method) scores (a measurement of delirium), the types of 'pressors' a patient was on (vasopressors or inotropes, drugs that affect vessel and cardiac contractility, affecting blood pressure and/or cardiac output), and daily ventilation values – or indicators for gas exchange in the lungs (e.g., respiratory rate, peep, FiO_2, SaO_2, PaO_2, etc.).

Throughout my time in ICU, I spent many hours at patients' bedsides, the nursing station, the clerical desk, and different offices and lounges getting to know the people, the practices, the terms, and the patients so that I could excel at my job and make friends. I always took great pride in being knowledgeable at work and competent in my role. As well, to adapt to the new culture I was now existing within, which was quite different from surgical culture, I needed to know more about my surroundings. I agreed to any opportunity to attend morning rounds, grand rounds, morbidity and mortality (M&M) rounds, staff meetings, the two-three debriefings that were ever held, and informal training or education sessions (both pre/post-Covid-19) to learn more about this environment. I needed to better understand the data I was collecting for my job, and become more knowledgeable of the unit's overarching goals, practices, and culture, so I could best comport myself and fit in with my colleagues.

I had never been expected to know so many medical acronyms, diagnoses, drug types, or interventions before, so my first many months in the ICU were quite overwhelming. I spent a lot of time asking questions like "What does this stand for?" "What does this drug do?" or "How do I know if they had a thrombectomy or an embolectomy?" In the OR, I knew all the surgeries, the case carts and the equipment, and was well-versed in human anatomy and physiology. I also knew almost all the reasons to come for surgery (common traumas, bone fractures, abdominal pains, and emergencies); however, critical care is a specialty area that requires special knowledge, which took time to learn. I had to become well-versed in dialysis and continuous renal replacement therapy (CRRT), intubation and respirators, sedation and medications, extracorporeal membrane oxygenation (ECMO), and many other topics of critical care.

I found transitioning to working in the ICU especially difficult since the people were tougher, they were not overtly kind or necessarily open to new people in their space, and they made that very clear. I started my job in the ICU when there were still veteran nurses working on the unit, in other words, nurses who had almost thirty years of experience (or more) and were experts in this domain. They were tough, but they knew exactly what they were doing, and they were the ones to ask if you needed help. They supported the unit and cared deeply for both patients and their colleagues, but they could be very intimidating to newcomers.

The patients in the ICU were also sicker, and the atmosphere was often tense or sad. I could feel the stress of being in the ICU, a fact that I also tried to ignore. Yet, due to my ongoing 'casual' employment with the operating rooms (and recovery rooms), I would continue to work evenings in these departments so I could remain a member of my old communities while escaping the ICU for a short period. Going back to the surgical culture felt like *home*, it was a place that I had adapted to, and I felt accepted and welcomed. This connection helped me to transition to the ICU more smoothly, as I would retreat to my community for refuge. Some of the recovery room nurses had also been long-standing ICU staff before working in PACU, so they would coach me on how to adapt to ICU culture. I would soon come to work fewer and fewer shifts in the surgical areas and more and more in the ICU, until I had been there for five years, having fully adapted to this environment as well. I eventually left my job at the hospital in May of 2023 to attain a healthier work-life balance.

Later, especially when reflecting on my experiences and writing the contents of this research project, I realised how the variety of environments I worked in had helped me to understand my research question. I was able to see both the contrast and coordination that existed between these various units that delivered either critical, acute, or surgical care, and how they would either cooperate or reach impasses. Patients would often need to be admitted to the ICU directly following complicated or long operations, if they required emergent or trauma surgeries, or if they failed to recover (e.g., breathe on their own) after surgery, meaning, these departments shared a lot of resources and patient experiences. The ICUs were intimately connected to the surgical departments. The complex nature with which these high-stakes areas of medicine succeeded in coordinating themselves would have been hard to understand without knowing the different units and wards, or what I may refer to as different cultures and communities.

Because of this, my initial research question looked much different at the start of my degree than it does today. In early 2018, I simply wanted to understand why healthcare providers seemed to be so exhausted and 'burnt out' – but I had no conception of how to organise my thoughts or put words to the phenomena around me. I began by studying different phenomena (e.g., burnout or moral distress) in the literature and spent a long time considering what they meant for my local hospitals. It was like a puzzle I just couldn't solve, everything seemed to rely upon more money, more resources, and more time.

Eventually, I would acknowledge how my own experiences had led me to exist (for thousands of hours) in diverse areas of care, allowing me to deeply feel inside what these environments can be like, making it natural to extend this knowledge to my research. As much as I wanted to obtain direct quotations from the caregivers I worked with, the degree to which I desired to understand their individual lives felt burdensome and almost invasive. I had hundreds of situational and personal questions to ask, and these critical care workers had already been studied by other researchers. As an alternative, I decided to study myself. The details around choosing self-study will be discussed in more detail in section 1.3.

1.2 The Purpose of this Project

My years spent in academia and in hospital, as well as my various exposures in life to disease, illness, and death throughout the last thirty-five years, have all led to this project's culmination: the realisation that not only have patients suffered the ill-effects of the Canadian healthcare system, but the people working within Canadian hospitals have also been victims. Public hospitals are complex machines that require a lot of financial support, resources, and human power, and when there isn't enough to go around, caregivers are usually the ones left trying to 'fill the gap' or 'pick up the slack' – a solution that wears thin very quickly. The detrimental effects of relying continuously on overburdened caregivers to counterbalance the failings of a health delivery system are many, some of which will be thoroughly explored in this project.

I have chosen to refer to medical staff throughout this project as 'caregivers' and 'caretakers' – which can be distinguished respectively as medical personnel who directly care for patients (i.e., their bodies and minds) versus medical personnel who organise or orchestrate care for patients, sometimes without ever meeting them face-to-face.[13] I prefer these terms to 'healthcare providers,' 'health workers,' or even 'medical staff' because the primary focus of this project is to advocate for an ethic of *care* and to emphasize the caring role of medical personnel. I have been primarily a caretaker, someone who organises care, and thus I have had many opportunities to observe and engage with various caregivers, those who directly deliver care. The distinction between caregiver and caretaker is not necessary for my arguments per se, I simply decided to choose consistent terms with which to refer to the medical workers in this project, terms that were anonymous yet carried a degree of specificity. The

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[13] I will distinguish between "caregiver" and "caretaker" in the following way in this project: a *care-giver* is someone who delivers care directly to patient bodies or who engages in actions that directly or immediately affect the patient's body, e.g., surgical incisions, drug injections, changing bedpans, or fluffing pillows. Caregivers can be anyone at any time (including helpful family members), but I will predominantly use this term to signify professional caregivers, i.e., nurses, physicians, radiologists, pharmacists, technicians, etc., who are the primary focus of this research. Conversely, a *care-taker* is someone who is involved in organising and/or facilitating the caregiving process in a more tangential manner, for instance, this may include support staff who work with patient data, clerks who organise the medical unit and facilitate patient bookings and appointments, computer programmers, software developers, administrators who organise care, or biotechnologists who develop machinery that scans the body, etc. I will predominantly use the term caretaker to signify healthcare workers such as unit clerks, staffing personnel, biomedical staff, housekeeping, etc. These terms are fluid, and at any moment a caregiver may assume the role of a caretaker, and vice versa.

terms caregiver and caretaker are also a nod to Joan Tronto's concepts of "Taking Care Of" and "Caregiving."[14]

Being a caretaker was a role that had its own benefits and challenges, some of which were shared with the caregiver, and some of which were unique. Consider how the caretaker does not necessarily have to get their hands dirty: if a patient is bleeding profusely, a caregiver usually deals with this. However, this does not mean that the caretaker will be unaffected by the incident. The caretaker might be the one on the phone with the blood bank urgently requesting assistance, and both the caregiver and caretaker share in witnessing the patient bleed out. The caregiver will probably be the one to tell the family that their loved one has passed away, however, the caretaker will be the one to prepare the death package and call the morgue to pick up the body. These circumstances may provoke stress in different ways, but they are still impactful for both parties.

Caregivers are featured centrally in this project. I often refer to physicians and nurses as they are usually the ones formally responsible in many contexts (i.e., "MRP generally refers to the physician who has overall responsibility for directing and coordinating the care and management of an individual patient at a specific point in time," according to The Canadian Medical Protective Association (College of Physicians and Surgeons Manitoba, 2023). Physicians are sometimes thought to do more 'caretaking,' if we imagine how they write prescriptions, look at x-rays, or round at the bedside; whereas nurses (who are at the patient's bedside 24/7) are considered to do much of the caregiving, by inserting IVs, cleaning the patient, monitoring their vitals, drawing blood, and performing tests. However, these role distinctions are too stark and do not account for the nuance embedded in each profession.

Caregivers also play a central role in my storytelling because many situations in surgery and critical care mainly involve physicians and nurses, since they are essential for this type of 1-1 caregiving. This does not mean that other types of caregivers and caretakers were not equally involved or present for these experiences (e.g., perfusionists, anaesthesia techs, respiratory therapists, or radiologists – in *addition* to nurses and physicians) I simply do not name them directly. The degree to which I was responsible for organising the care delivered by allied caregivers (in my role as a caretaker) was less common for pharmacists, physiotherapists, dietitians, and others than it was for physicians and nurses. Lastly, to ensure anonymity, it was also easier to focus each story on a particular individual or set of individuals rather than to provide an exhaustive list of who was there.

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[14] Tronto, a political moral philosopher who will be heavily referred to in Chapter 6, considers "Taking Care Of" to be the act of taking responsibility for an identified need for care and deciding how to respond to it, such as sending money for care services, or sourcing a healthcare provider who can deliver a specific type of care; whereas "Caregiving" involves directly meeting a person's need for care, such as administering their medications, fixating their broken bone, or doing their laundry (1993, p. 106-107). The term 'caregiver' is also more flexible and refers to a broad range of people including but not limited to pharmacists, unit aides, physiotherapists, physicians, nurses, or patient attendants.

Transitioning back to the purpose of this project, I want to clarify the inspiration behind this work. When you work in a hospital, you know that it is easy for patients to be unintentionally harmed by the system, and it is also not news that a very tired, run-down, and disillusioned caregiver may make a mistake or even stop caring for a little while. These things happen all the time. You also probably know that it is natural for a person to make mistakes or withdraw emotionally when their own needs are not being met. During my time in the hospital, I thought many times that I would quit or that I would abandon the difficulty of it all. When I felt sick, when I felt frightened, when I felt judged or hopeless, and when things felt wrong, I would think: "I don't *need* to be here." But instead of quitting, I shifted my perspective and decided that I wanted to help make change from inside the system. How to achieve this, I had no idea. In fact, for most of my years in the hospital, I could not even put words to the things I was witnessing, I could only point to them and say, "*This* is not working for us."

When I finally made the following realisation – that caregivers often attempt to absorb, deflect, or prevent harm to patients when things get tough, which can often mean they are the ones who are harmed instead – everything changed. This realisation shifted my focus away from a one-dimensional view of patient harm and towards a more dynamic system of harm that affects everyone, caregivers included. This refocused my understanding of how the structure of medicine (which is a tangle of cultures, spanning the practice and education of medicine to research and innovation) and the siloed culture of medical units (like critical care) can affect everyone involved in both caregiving and receiving. Having witnessed the different ways caregivers and caretakers suffer from systemic abuse, neglect, and harm – all of which can be summarised by the concept of "not being cared for" – would later draw my attention to the pervasive levels of mental unwellness, psychosocial stressors, and physical illness that caregivers seem to develop during their careers.

I developed a fascination with the cultural and systemic restrictions that caregivers seemed to be beholden to; whether or not these restrictions constituted actual 'rules' or were simply culturally enforced 'habits,' I knew that either way these phenomena had to survive through institutional surveillance or through a process of self-monitoring (Foucault, 1975, as cited in Rabinow, 2010).[15] Having now spent many years working in hospitals, I was able to examine a host of experiences I had witnessed where caregivers would struggle daily to protect and provide for patients, often at great cost

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[15] Foucault writes in *Discipline and Punish* (1975): "The disciplines have to bring into play the power relations, not above but inside the very texture of the multiplicity, as discreetly as possible, as well articulated on the other functions of these multiplicities and also in the least expensive way possible; to this correspond anonymous instruments of power, coextensive with the multiplicity that they regiment, such as hierarchical surveillance, continuous registration, perpetual assessment and classification. In short, to substitute for a power that is manifested through the brilliance of those who exercise it, a power that insidiously objectifies those on whom it is applied." Foucault discusses the coercive mechanisms of the "panoptic modality of power" which harnesses the observational and judicial power of the individual themselves to self-monitor and self-surveille their own need for discipline, which was a more economic and effective way to govern bodies in societies or institutions (p. 305).

to their well-being. Through years of working in different areas of care and with various healthcare teams, one fact became glaringly clear to me: how little care and support the caregiving team receives for the work they do, beyond monetary compensation.

My thoughtful response to addressing harm in medicine is to 'care for the caregiver,' since "It stands to reason…that properly cared for caregivers will provide better care for residents" (Pullman & James-Abra, 2001, p. 38), and most importantly, because caregivers *deserve* to be cared for. The length of time that I dedicated to understanding this topic (and hospital culture) – recalling fifteen years of immersion in this environment – is not out of the ordinary for what is considered to be traditional ethnography (an immersive research methodology) where researchers might choose to spend ten or more years living and working with/around the subject of their attention; however, the fact that my witnessing must now be conducted *retrospectively* and through memory alone is less common. When I started working in healthcare my research question had not yet been conceived, or even dreamt of. I simply joined this group willingly out of a desire to become a healthcare worker, but little did I know that later I would use this knowledge and experience as qualitative data derived from lived experience to better examine professional wellbeing.

My interest in this project is focused on the emotional harm to caregivers working in hospitals, and specifically on how more can be done to acknowledge the natural suffering and grief that comes along with caring for patients. I feel that now is the time to address this gap in contemporary hospitals. The finished product, the project itself, i.e. "Defending an Ethics of Care: An Autoethnography Reflecting on Emotional Health in Critical Care Medicine" is a summary of everything I feel I have learned about this topic to date.

1.2.1 Summary of Chapters

Chapter One: in which we are currently located, provides background information on myself, as an author, a researcher, and a storyteller. This chapter is dedicated to explaining my personal history and the path I took working in a hospital. I recount my years spent working in medical areas of care, I situate my research and provide details about my methodology, the interdisciplinary nature of this work, the theory that I draw upon, and lastly, I provide my data and evidence. Six themes emerge, which help structure the subsequent five chapters: awareness, identity, integrity, emotional labour, alienation, and care work.

Chapter Two: explores the problem of occupational stress by defining key terms and concepts like burnout syndrome or trauma and provides an overview of the literature and developments around occupational stress in medicine. I introduce the issue of burnout more generally and outline some of the major players involved in defining and measuring burnout. I also engage in a discussion about how stress affects the mind and the body of individuals, and how stress can literally change the brain.

Chapter Three: begins by describing the intensive care unit. I outline the type of care provided in the ICU, how the care is generally structured, and what types of services are delivered. I describe how the ICU is both a professional place of work and a social and political environment that is shaped and operated by a culture of people. This chapter also explores the demands of medical life and why it is thought to be stressful.

Chapter Four: explores the concept of identity, the liminal nature of medical personalities, and how professional identity necessarily crosses over into one's personal life. The lifestyle of caregivers is essential to their identity and the care work they provide (the quality of which reflects their values and requires integrity). This chapter is focused on the ways in which pedagogy, mentorship, and individual character all help to shape the lives of medical persons and how this process of becoming is not always beneficial.

Chapter Five: is a discussion on how caregivers are constantly engaging in emotional labour, a type of labour related to the production and management of personal emotions according to what are called "feeling rules," that is, an invisible structure of hegemonic governance over what is considered to be 'appropriate' to feel within a particular culture or subculture. This silent phenomenon of having to consistently obey feeling rules has a lasting and damaging effect on the minds, bodies, and emotions of caregivers. Caregivers who are separated from their own feelings, and those of others, may begin to feel alienated in the workplace.

Chapter Six: provides an outline of the history of Care Ethics, an ethical theory that purports to show how relationships are central to moral knowledge and action. Put forward by authors and social scientists like Carol Gilligan and Joan Tronto, care ethics stresses the importance of the political and private boundaries between distinct types of caring activities, and the effects these divisions have on the individual. Many feminist positions/opinions on 'care' are presented, and I engage with the importance of developing trust and learning to care for others.

Chapter Seven: is where I tie the above concepts (and core themes) together to show how the cumulative effects of silencing emotion, breaking trust, compromising one's integrity, alienating staff, and failing to care – *all* affect caregivers by creating cognitive and emotional dissonance, internal disagreement, and can lead to coping behaviours that may operate to reject the self, such as denial of said sadness, repression of crying, or even anger at the self for feeling sadness to begin with. This ultimately leads to fakeness (not displaying how one truly feels), resentment (anger at not getting what one needs), and therefore, resistance to continuing to care for others given a repressed internal need to be cared for.

Chapter Eight: is the conclusion of this project and presents both my general theory and suggested solutions. I recommend ways to combat carelessness and shift the culture of medicine to be a more truly empathetic one, which requires having open avenues for expressing emotion and processing grief.

1.2.2 Situating the Research/Researcher

This project is rooted in *autoethnography*, which is "an autobiographical genre of academic writing that draws on/analyses/interprets the lived experience of the author and connects researcher insights to self-identity, cultural rules and resources, communication practices, traditions, premises, symbols, rules, shared meanings, emotions, values, and larger social, cultural, and political issues" (Poulos, 2021). Autoethnography is a sub-grouping of *ethnographic* research, which is an anthropological method of using participation (in the research) and observation (of things, events, and others) as a means to understand a research subject. At its core, an ethnography (as a written text) provides "a scientific description of the culture of a society by someone who has lived in it, or a book containing this," since "one of the aims of ethnography is to contribute to an understanding of the human race," such as Malinowski's several ethnographies of the Trobriand Islands (Cambridge Dictionary, 2024).

Ethnography, for our purposes here, can be thought of as an umbrella term which refers to the overarching processes involved in a particular type of observation and investigation (and focuses heavily on social relationships and culture). Ethnography typically examines a group of people outside the researcher, whereas in autoethnography, that same observational lens is directed and applied to the self. How the autoethnographer examines the self brings the facet of autobiography to the text. Similar ethical and political considerations must be made for both ethnographic researchers and autoethnographic researchers, where the risks involved apply to the people/person being studied (for the ethnographer, this will be people external to the researcher's gaze, and for the autoethnographer, it is the researcher themselves). My ethnographic method has also been combined with critical theory which is what makes this study a 'critical autoethnography.' In this project, I use my own personal experience to analyse the broader cultural experiences of operating in critical care medicine.

Donna Henson writes in *Girl, Disrupted* that, "Autoethnographers write eloquently of the signification and transformational power of story" and that "stories matter because stories shape selves and lives" (as cited in Adams et al., p. 344). Specifically, and as conceptualised by Adams and colleagues (2015), autoethnography:

1) uses a researcher's personal experience to describe and critique cultural beliefs, practices, and experiences;
2) acknowledges and values a researcher's relationships with others;
3) uses deep and careful self-reflection—typically referred to as "reflexivity"—to name and interrogate the intersections between self and society, the particular and the general, the personal and the political;
4) shows people in the process of figuring out what to do, how to live, and the meaning of their struggles;
5) balances intellectual and methodological rigour, emotion, and creativity;
6) and strives for social justice and to make life better" (p. 1-2).

In autoethnography, the *self* becomes an important part of the ethnographic process, but never in isolation. The self is always observed "in relation to others and to the social, political, and economic systems of power in which it is embedded" (Gillespie, 2021, p. 2). The researcher takes on a central role as their own experience becomes the fulcrum from which others' experiences and narratives are extended and viewed. Further, Gillespie writes "as a feminist practice, in particular, and as one focused on transforming unjust social relations, autoethnographic research can offer a methodological manifestation of the personal as political" (2021, p. 2). Thus, for the autoethnographer, "storytelling is no longer unproblematic," and how autoethnographers choose to represent themselves and others is highly important, because "who gets to tell whose story" also matters (LeCompte, 2002, p. 289).

All researchers, but particularly all ethnographers (including autoethnographers) are strongly encouraged to take steps towards acknowledging their *situatedness* or *positionality.* Situatedness and positionality – or one's social, political, historical, and geographic 'situation' in life – can be understood as a person's relationship to themselves, others, and the social world around them. How we understand ourselves, comport ourselves, and experience things that exist outside of us, will help to shape our beliefs and ideas. These beliefs/ideas further influence what we can see, think, and feel as individuals, and can further have consequences for those around us (e.g., tolerance/intolerance) through our actions. "Situatedness is a theoretical position that posits that the mind is ontologically and functionally intertwined within environmental, social, and cultural factors. As such, psychological functions are best understood as constituted by the close coupling between the agent and the environment" (Costello, 2014).

The purpose of acknowledging one's situatedness is multifaceted in that specific affiliations – either with religious, cultural, or social milieus, or the adoption of particular thoughts and behaviours – will affect a researcher's ability to process, understand, and *know* things about other people who are involved in different ways of being (i.e., those that are foreign to the observer). Since the purpose of ethnographic work is literally to "construct a culture through the process of research and writing" (Naaeke et al., 2012, p. 152), what is ultimately constructed by "the perspective the researcher takes" will impact "the research process, the findings of a study, the argument made by the researcher about the implications of these findings" and thus, "the knowledge produced about that cultural group" (Naaeke et al., 2012, p. 152).

Those who are seen as 'other' to the researcher (who is looking to obtain information and gain an understanding of the other) may influence how that researcher views them, that is, as different, or outside of themselves, which can obfuscate the truth or meaning of the data being gathered. 'Othering' can be "divided into two steps: categorising a group of people according to perceived differences, such as ethnicity, skin colour, religion, gender or sexual orientation" and "identifying that group as inferior and using an 'us vs. them' mentality to alienate the group" (Curle, 2020, para. 4). This can further lead to the harmful misrepresentation of a person, group of people, or institution through being misquoted, misunderstood, or slandered due to the presence of deeply held and unexamined beliefs and judgments (e.g., racism, classism, ageism).

Ethnographic researchers have had to shift their point of departure greatly from simply trying to describe specific cultures of people from a seemingly objective viewpoint (see: Hose & McDougall, 1912), which assumes the neutrality of the observing scientist, to instead becoming more aware of "institutional racism, asymmetries of power and status, patterns of neglect and ignorance, and even legitimised greed and corruption that systematically disadvantaged subordinate groups" (LeCompte, 2002, p. 285). Brewer (2000) writes, surprisingly ethnography "has been subject to the most criticism by ethnographers themselves…[and] has seen the greatest debate about its theoretical and methodological suppositions" by these researchers (p. 6). Butz and Besio (2004) explain how an ethnographer's awareness has come to "two central responsibilities: to identify and analyse the lingering effects of colonialism, and to contribute to processes that dismantle those effects" (p. 350).

Understanding the past wrongdoing that has been associated with ethnography is vital to knowing how to apply its use appropriately today. Contemporary ethnographers must do better than those who came before them and are tasked with having to engage with the problems of accuracy, reliability, representation, realism, validity, and reflexivity in their work. Researchers who choose to do ethnographic work now must engage closely with the application (possible harms or benefits) of their methodology, and later, how these chosen actions might affect participants (such as how the narrative portrays these individuals, how the effects of the research will play out, and overall, whether this knowledge benefits these individuals or stigmatises them).

No matter how conscientious a researcher is to be mindful and respectful of their presence in a group, this presence will undoubtedly alter the nature of the environment, creating a sort of observer effect.[16] The concern with observer effects is that they "will somehow bias and therefore invalidate research findings" (Monahan & Fisher, 2010, p. 1). Researchers must acknowledge the difficulty of overcoming "observer bias" and should seek to ethically shape the politics of different groups and to empower those individuals rather than oppress them. The assumption should never be that people lack capacity, power, or autonomy (or self-rule). Instead, researchers should presume that people have the capacity, are powerful, and have a right to self-governance and free choice. The participants of research should also be treated as if they *know* what is best for themselves and their community, and this should not be doubted unless there is evidence to prove otherwise (e.g., through a capacity assessment for a particular individual; or the acknowledgement of vulnerability in a particular situation, or a failure to uphold principles like justice).

Autoethnography is an ideal methodology for researchers (such as me) who are closely entwined with their area of study, and thus who find it difficult to separate themselves from the data. For this research, I chose to engage in autoethnographic practice because I am both an *insider*, one who works and operates in a hospital legitimately (i.e., being officially and legally employed by an institution that I work in daily), as well as an *outsider* (i.e., at different times I have been someone who has existed outside of the institution, the culture, or the structure of the healthcare network). Whether or not a person is an insider, or an outsider is not black and white. Naaeke and colleagues distinguish between emic (insider) and etic (outsider) perspectives in simple terms: the former constitutes a researcher who is a member of the community being studied, and the latter constitutes a researcher who is not part of the community being studied (2012, p. 152).

Despite this simple definition, they further demonstrate how complex and overlapping these two perspectives can become. The division between the two states is not always clear cut, since it takes time to become a true insider, that is, to be accepted and learn the deep cultural ways of communicating and being in a space, and it can take time to shift well-formed outsider beliefs, understandings, and behaviours that have been preconditioned. Insiders and outsiders can also change their status. For instance, a person may be an insider for years only to suddenly leave the profession or transfer to work within a different type of medicine where they are again an outsider. Emic and etic privilege can shift in either direction.

Whether a researcher is positioned within or outside of their culture of interest will have positive and negative effects on the research being conducted. In some cases, a researcher may benefit from being an insider: for instance, one researcher claims that "As an insider I know the language of the Dagaaba as well as the narratives that I now analyse," giving them the advantage of being able to

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[16] The observer effect is a term originating in quantum physics and refers to the recognition that when researchers interact with a system (usually through the instruments of measurement or by observation) they can change the phenomenon being studied or alter the behaviour of what is being observed (e.g., quantum particles) (see the *Double Slit Experiment,* Gregg Jaeger, 2009).

intuit and make quicker sense of the myths, stories, and sacred writings that they were already familiar with. Conversely, this familiarity may also blind the researcher to new ways of viewing these texts (Naaeke et al., 2012, p. 154). Another researcher writes, “Sometimes informants think that I should know the answers to some of the questions I ask because I grew up among them” (Naaeke et al., 2012, p. 154). A benefit of being an outsider is that they tend to see things with fresh eyes and may ask questions that will seem obvious to the insider, however, the outsider must also spend time and energy to adapt to and understand the insider's world, sometimes without ever fully succeeding. This ‘double-edged sword’ then applies to both groups.Ethnographers recognise these many limitations to their research methodology. Even though questions about accuracy and objectivity come up against the qualitative investigator's more artistic and dramatic methodology, researchers must remain faithful to the ethical commitments set out for participants while still attempting to ‘accurately’ depict the social events witnessed in the field. Monahan and Fisher (2010) argue that “instead of aspiring to distance and detachment, some of the greatest strengths of ethnographic research lie in cultivating close ties with others and collaboratively shaping discourses and practices in the field” (p.1). They further argue that “Informants’ performances – however staged for or influenced by the observer – often reveal profound truths about social and/or cultural phenomena” (p. 1).

Throughout this thesis I engage in a process of deep self-reflection to have an “active and reciprocal relationship with [my] audiences – one marked by mutual responsibility and participation” (Adams, et al. 2022, p. 7). In other words, I do not wish for my statements here to mark an immutable truth, instead, the readers of this project should note that this is *my* story alone, even though it includes the influences of many other people. These individuals have their own voices and perspectives which have not been fully represented here. For this reason, I humbly welcome challenges to my experience and my perspectives since my story represents only a partial truth.

The point of this work is not to be passive, voyeuristic, or even objective; instead, I look to transgress the colonial habits of the past (those that sought to portray a specific ‘truth’ or control the ways of others) and realise that “there is no neutral space from which we write or from which we read” (Adams, et al., 2022, p. 42). In this project, I not only critically reflect on the diversity of the people I am connected with, but I also consider the intersectional individual that I am.[17] The different aspects of both my personal and professional identities, which I may adequately acknowledge here (or fail to), equally affect my analysis of the subject matter at hand, that is, an analysis of the stress of caregiving as well as an analysis of my stress as a unique individual.

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[17] The use of the term “intersectionality” here is taken from Kimberle Crenshaw’s notion of intersectionality, which she uses “to deal with the fact that many of our social justice problems, like racism and sexism, are often overlapping, creating multiple levels of social injustice” (Crenshaw, 2016).

I acknowledge that because I have experienced group-based suffering myself in the past, I have been drawn to understanding different modes of oppression, exclusion, and intolerance (e.g., racism, sexism, classism) as well as behaviours associated with such prejudice and abuse (e.g., silencing, controlling, subverting, overt harm). These interests eventually drew me to ethics and philosophy at the end of my undergraduate degree, where I shifted my focus from pre-medical courses in biology and physiology to healthcare ethics and feminist theory. It was only later in life that I realised why I felt such a strong desire to stand up for others, to define ethical behaviour, and to understand the full scope of justice in healthcare – I knew what it felt like to be abused, ignored, and silenced.

To situate myself for the reader, I can begin by disclosing that I have been quite privileged all my life. I have always been a part of what would be considered middle class (throughout the late ‘80s, all the ‘90s, and the early ‘00s) during the years I spent at home as a baby, child, and teenager. My family was never able to spend a lot of money, but my twin sister and I also never had to worry about food scarcity, homelessness, or poverty. We always had good food and clean bedding, and we lived on a beautiful lake property which taught us to appreciate nature. We ended up spending most of our time outside in the woods making our own fun (e.g., building forts, climbing trees). I will disclose here that I am a Caucasian, white-skinned, Canadian-born, European-descended (of Scottish descent), English-speaking, female, cis-gendered, able-bodied, middle-class, university-educated, non-denominational, non-partisan (yet liberal) woman.

As a result, I am likely predisposed to specific beliefs, attitudes, biases, and possible blind spots in my awareness. To address my conditioned agency in this work, I will always attempt to see and declare my biases when I am aware of them, even if I will never be fully aware of them or overcome them, and I seek input from others about the aspects of myself they see better than I do. In this project, I attempt to be as transparent as possible about how I have been very privileged, how I have been given many opportunities that others will have not (or were denied), and because of my white skin I have at times been easily trusted or accepted more quickly than others, a fact that may have also made me appear untrustworthy to others, and I am thus positioned within a space of colonial power.

I am also privileged in that I can work and live in my home country of Canada, where I am a citizen who speaks the predominant language (i.e., English), thus, I know the customs and rules of my country and am well familiar with the culture I operate in. I acknowledge that I live in Mi’kma’ki, the traditional (or ancestral) territory of the Mi’kmaq people. Further to this, I am privileged in that I am able-bodied and thus can move freely in spaces that have been designed with able-bodied people in mind, without the need for assistance. I have little trouble navigating the social and political environment, I have a university education that has allowed many doors to open for me, including being able to attain work easily, have a modest income while going to university, and therefore, be able to find clean and safe places to live and the ability to afford healthy satiating food. Having been employed fully since I was seventeen years old, I also feel well supported by my government and home province.

Identifying as a woman has been a double-edged sword in that some people in my life, or the workplace, have been quick to embrace me (either those who are like me: women in medicine), whereas others were quick to ignore or dismiss me (often powerful men). Being a woman, I have not always felt comfortable in my body, and I have often lacked confidence when it came to speaking up for myself or ensuring that I had what I needed when I needed it. I have also been touched by personal trauma where aspects of my childhood were riddled with fear, a sense of being unloved and uncared for, and entrenched with anxieties around safety and protecting the self. Over the years, especially those years I spent working in hospitals, I gained a sense of personal power around what it means to be 'me,' and I have learned to appreciate that I am a unique person (like everyone) who is quite emotionally sensitive and caring. These features of my personality have been cherished by those I have been in close relationships with; however, it has always felt like a weakness in the world of medicine – something to be ashamed of.

1.2.3 Interdisciplinary Research Design

This research project was conducted as part of my doctoral work and is a partial requirement for the completion of the Interdisciplinary PhD Program at my university. My interdisciplinary studies allowed me to draw on different academic bodies of knowledge (e.g., medicine, bioethics, feminism, psychology, psychiatry, philosophy, sociology, and social anthropology) to help me analyse my topic – that is, caregiver burnout and emotional management. The original goal of this research project – its early conception – was to better understand exhaustion, compassion fatigue, and burnout in medicine both in the literature and in practice. I imagined that if I could learn what was causing so much distress, I could more narrowly focus my research question. After narrowing my research question, I could then design a research protocol to effectively collect data to help me better see the root cause(s) of deeply held occupational stress.

Already, countless surveys (Maslach Burnout Inventory/MBI, Oldenburg Burnout Inventory/OBI, Single-Item Burnout Measure, the Copenhagen Burnout Inventory/CBI, Stanford Professional Fulfilment Index/PFI, Wellbeing Index, or the Healthcare Satisfaction Survey (NAM, 2023) were being used globally to assess healthcare provider wellbeing, yet, despite the many factors that were believed to contribute to occupational stress, little had been done to pinpoint solutions to counteract this epidemic. After conducting surveys, researchers who wanted to better understand these phenomena could further conduct interviews, focus groups, and/or attempt to trial interventions to see how effective they were (by re-administering the wellness surveys after implementing the intervention for a while and then determining whether the wellness scores improved).

My early plan was to administer the MBI to intensive care staff, conduct interviews and focus groups with them, and analyse the results which would be used to inform prospective interventions. Soon after, one of our ICU physicians administered the MBI to ICU staff and conducted interviews and focus groups with them, meaning there was no longer a need to administer wellness surveys to this group, nor a need to conduct interviews (as to not exhaust the staff further, nor overburden them with the demands of research). This physician's data granted the critical care community access to recent quantitative data that showed the numerical ratings and percentages of burnout and levels of moral distress. During interviews, they also collected detailed narrative information related to what was stressful about working in the ICU, which was categorised for analysis. You can find this information in Figure 7, and it will be discussed later.

For my research purposes, I wanted to support and expand upon the baseline data on this topic, including metrics gleaned from surveys, interviews, and so forth, collected by this researcher as well as others across Canada and globally, by conducting qualitative research using self-study. To effectively analyse the subject matter of 'burnout' and 'emotional management' – on a deeper level than measurement and categorization – I knew that I would need to dive deeply into the feelings of personal distress and hospital experiences, which can be accomplished using self-study. I also wanted to draw on the strengths of various related and unrelated disciplines for their unique contributions to the distress literature, resulting in a mixed-methods research design. Thus, this research is *interdisciplinary*, and the style of this dissertation is unique in that it blends genres and mixes ways of collecting, analysing, and presenting evidence. Therefore, if you find the genre or structure of this work unusual, I will tell you now that it does not fit any one mould, however, each choice was made very intentionally.

My studies have focused heavily on ethnographic and autoethnographic research methodologies, the philosophy of medicine, the tenets of healthcare administration, and feminist literature, to conduct a research project that could weave together theoretical work, empirical work, and my own reflections as a caretaker, to determine whether repressed, ignored, or unprocessed emotions were contributing to occupational stress, and whether the ways in which ICU teams approach distressing situations (potentially ignoring emotion, or shaming medical personnel who get emotional) can contribute to a caregiver's overall occupational stress. A secondary goal would also be to help provide solutions for burnout, trauma, and occupational stress, to relieve stress for people working in critical care medicine.

This project is academically supported by a graduate committee, the members of whom are representatives of and hold expert knowledge in many of these respective fields. The theoretical lenses used to analyse the data include various philosophical theories, theoretical and applied ethics, action anthropology, ethnographic anthropology, qualitative medical research, narrative medicine, and critical sociology. Since the data constitutes a recounting of my own experience with occupational stress, I am re-telling my own life story as I attempt to bring outsiders into the spaces where this took place to elaborate on the sensations, thoughts, and feelings that accompany it. In this research, the self-study (or autoethnographic) aspects are used to collect the data (or to put it to paper), thematic analysis is used to code, organise, and analyse the data (to generate meaning from it), lastly, I apply higher-theory to my personal data so that we can better understand how my evidence (the core themes derived from my work) fits into the context of global literature on occupational stress.

Many of the themes that I present in this project appear, at first, to be discrete phenomena, in other words, unrelated to each other. However, upon closer examination, and throughout the chapters of this project, I hope the reader will begin to see how I was able to piece these phenomena together like a tapestry woven of individual threads that overlay and crisscross to become more and more indistinguishable. Some phenomena are related to individuals alone, such as how healthcare providers uniquely process emotion, e.g., the caregiver who cries at the bedside, versus the caregiver who refuses to engage in public displays of emotion. On the other hand, some phenomena are related strictly to the institution or its politics. Take for instance the rules or policies that govern a healthcare institution, the strategic plan that has been put in place (i.e., the vision, mission, and values), or the capitalist regime in which this institution functions.

Many of the themes are also commonplace concepts, in that they are not novel, such as ideas about a person's professional identity, how we care for each other, or feelings of belonging or alienation in the workplace. These themes were novel for me, in that they were drawn from my personal data and experience; however, other researchers, academics, and thinkers have stumbled upon these ideas already, and have worked very hard to put language to these phenomena and/or to advocate for the formalisation of these concepts and argue for their importance. As the reader, you will see less engagement with contemporary texts within our discussion on the themes, this is because I attempted (as a grounded theorist[18] would) to engage very heavily with my autoethnographic data to make sense of and draw out the core themes. By untangling my own data, I was able to draw out common struggles by caregivers, while also presenting my own view of how these problems operate at the local level within a unique community setting. High-level theory then played a role in the final critical

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[18] Grounded theory: Barney Glaser and Anselm Strauss' (authors of Awareness of Dying, 1965) developed what they called grounded theory, a process that allows researchers to generate a theory "which is 'grounded' in data that has been systematically collected and analysed" (Noble & Mitchell, 2016, p. 34). Grounded theory differs from traditional ethnography in that it seeks to generate a theory. A theory related specifically to a defined 'problematic' rather than looking to culture as the sole basis of understanding (LeCompte, 2002). Grounded theory starts on the ground, and it works its way upwards. Researchers are not expected to review existing literature or theory, since the expectation is that you will study your own data to generate a new theory, one that is derived from the actual content of the lived experience of the informants who shape your work. This methodology is widely adopted today and has been carried forward by subsequent authors such as Cathy Charmaz, Juliet Corben, Judith Holton and even the popular author, TedTalk host, and social scientist Brené Brown (Brown, 2010).

analysis of this work and promoted my ability to make sense of the data and how it directly affects our lives as relational beings.

While researching this topic, I became grateful to have had varied experiences in medicine. This is because working in a siloed institution can make a person blind to the very objects of their everyday attention. People become accustomed to their own cultures through constant exposure to the day-in, and day-out practises and activities, such as how emergency medical staff become used to trauma and death. This type of constant immersion can make it difficult to see the hegemonic influences (i.e., the relatively dominant ways of being, or the strongly influenced values, norms, ideas, expectations, worldview, and behaviour that is inspired by the ruling power) at work (SEP, 2023). In other words, it is harder to notice what might be *different* or *unique* about your environment if you are always in it. Medical personnel are subject to institutional rules and unspoken codes of conduct, meaning, they may hold blind spots in areas where they have been indoctrinated to the ways of being that they perceive to be "correct" in their work.

To successfully see otherwise, it can be helpful to look at things from a vantage point that is perched outside of one's normal worldview. I was given the benefit of such an external vantage point by being able to come and go between different departments, hospitals, and areas of care. This allowed me to see the similarities and differences between the units through these contrasting experiences. Some experiences were shared, and others were completely unique. The culture of each community was also very specific, making the atmosphere or energy of a unit very particular and palpable. Employing various interdisciplinary viewpoints from my experiences (both inside and outside of healthcare) and the extensive literature review conducted for this project has allowed me to analyse many contrasting opinions and perspectives, further fleshing out my unique understanding of occupational stress in medicine.

1.3 Methodology and Theory

From my experience, it took many years to adapt to and formulate a general baseline understanding of the healthcare environment in which I found myself. It took labour, cognitive strain, energy, sweat, courage, and sometimes tears to gain more context, more trust, to know what I was seeing, to know who I was working with, and to know what I was talking about or doing. My daily experiences included dealing with/reasoning with/decision making with/experiencing: patients, patient families, surgeons, fellows, anaesthesiologists, anaesthesia assistants and techs, perfusionists, intensivists, medical staff and consulting services (e.g., nephrology, palliative care), residents, medical students, nurse practitioners, nurses, pharmacists, dieticians, physiotherapists, care team assistants, patient attendants, unit aides, unit clerks, housekeeping, and many more.

From day one onwards I was uncovering new information every minute, hour, and day, embodying more and more of what medicine meant to me and what I thought it meant to others. I learned quickly and I asked a lot of questions. I did not refrain from probing hundreds of caregivers to answer things such as “What does that mean?” “What is that for?” or “Why do we do that?” Graciously, most of them would happily explain this information (objects, signs, symbols, acronyms, phrases, or processes) to me, or demonstrate cultural practices and ways of behaving so that I could better fit in and understand others who were operating around me. In simple terms, I learned by watching, listening, thinking, ruminating, and doing.

At this early stage, I was not doing “research” as it is defined by the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2), i.e., “an undertaking intended to extend knowledge through a disciplined inquiry and/or systematic investigation” (Application of Article 2.1). Instead, I was simply being an observant and inquisitive individual. I had no recourse to take what I had witnessed or felt at the time and turn that information into actionable change in healthcare. Instead, any personal growth that I experienced as a healthcare worker seemed only important for my professional development. I was occasionally able to advocate for those in need when I had personal opportunities available to me, for example, to voice concern when I thought something was unjust, to complain when I thought something was important, or to empathise with patients or staff. Yet, to conduct proper research, I would later need to formulate a specific research question, determine my plan to investigate and answer that research question, carefully organise a methodology, and determine a process of analysis.

This research project is designed to examine the nuanced relationship between a person and their job, which includes a person's ability to cope with difficulty in the workplace. My self-reflection is focused on investigating phenomena that I have experienced that I believe connect to the foundations of *identity* and *culture* and navigating the *politics* of *caring* relationships in medicine. Examples of my experiences include feeling distressed or sad after a violent patient death, feeling fearful when bullied by a coworker, experiencing emotional abuse from mentors or superiors, as well as the many positive experiences I’ve had such as feeling relief after a debrief, satisfaction after honouring a patient, or feeling supported and cared for by a coworker.

My process entails thinking back through specific memories and experiences that felt particularly significant at the time, either to me or to others, and analysing those memories, whereby I then chose which ones to include in this project. When I reflect on other people, I reflect on whether those individuals appeared to be distressed (or not) from my perspective at the time and recount the experience only from my lens. I use narrative text to describe my past experiences (based on my observations of, and interactions with the specific communities I was a member of) all of which were analysed, categorised, coded, and are presented in later chapters as thematic categories. Each theme further undergoes critical, feminist, and philosophical analyses of what I feel have been salient features of emotional distress in healthcare. Many of my autoethnographic observations are held within the greyed-out text boxes, but many of my observations are also embedded within the body of this work.

1.3.1 Retrospective Autoethnography

Carolyn Ellis, an early autoethnographer who wrote *Final Negotiations: A Story of Love, Loss, and Chronic Illness* (1995) which is about her nine-year relationship and experiences with her mentor, lover, and friend Gene Weinstein who becomes ill and eventually dies from emphysema (p.3), challenged the status quo of her discipline. As a graduate student, she found herself torn between the "uninvolved and distant" (p. 6) approach she was taught in her training (i.e., objective observations) and her desire to engage as a participant in her research. She writes, "I struggled with the constraints of detached social-science prose and the demand to write in an authoritative and uninvolved voice. Though I worked hard to follow these principles, professors I admired still reprimanded me for having 'gone native' and for being too sympathetic toward my subjects" (Ellis, 1995, p. 6).

Her intuition was that she *was* a part of her own observational work and that she influenced the people she was spending time with. She says, "I wish now that I had placed more emphasis on how the people felt, which was my primary interest" and that "I also wish…that I had been more present in my writing about the fishing communities. Mostly, I describe 'them,' the fisher folk, interacting with each other, as though I am off in a corner, invisible. In reality, most of what I learned came through my interactions with the people, especially their reactions to me" (Ellis, 1995, p. 6). In my experience, almost everything I learned about the hospital came from having relationships with people, specifically, through the messy situations we found ourselves in, and the bonding that occurred over years of dealing with intensity and stress.

The task of ethnography, as defined by John Brewer, is to garner meaning from the everyday "ordinary activities" of "people in naturally occurring settings or 'fields' by methods of data collection…involving the researcher participating directly in the setting, if not also the activities, to collect data in a systematic manner…without meaning being imposed on them externally" (2000, p. 6). Since observation is the heart of ethnography, it is also at the heart of this work. When I say *observation* throughout this research project, I mean many things, which can include (but are not limited to) various forms of noticing, watching, thinking, looking, averting, hearing, listening, attending, straining, tasting, experiencing, smelling, avoiding, touching, recoiling, reaching, feeling, and ultimately, seeing and knowing.

In this project, I refer to *participant observation* (i.e., where an individual is both the observer and the observed) since the autoethnographic researcher is considered to be the primary participant of their research. However, participant observation in ethnography usually refers to the researcher taking part in the life world of those being observed or analysed; instead, the autoethnographer must deeply observe the self in relation to their surroundings and their experiences. In this case, this project is specifically a *retrospective* autoethnography (RAE) because the immersive part of the research (i.e., working in a hospital) already took place prior to the development of this research protocol.

RAE still "allows researchers to use their personal stories as data/material" and is a "method of inquiry [that] involves the researchers interrogating their autobiographies and observations retrospectively… using diary entries, field notes, or memory" for the purpose of giving voice to a particular group, although in this case, the voice we hear is that of the researcher who seeks to represent those who cannot/do not speak for themselves (Tripathi et al., 2022, p. 2). In this project, I reflect on and recall my own memories of working, learning, and growing as a person situated in healthcare spaces. At the time of being employed in medical environments, I was always required to meet new people, adapt to new rules and customs, and find ways to fit into various cultures that I had never been a part of before. This involved learning to trust others and have them trust me, learning to speak the language by decoding signs, symbols, acronyms, and terminology, as well as learning how to behave and navigate such complex situations in order to become a part of the overarching 'care team.'

According to Tripathi and colleagues "retrospective not only means that the described event has already taken place but denotes that the researchers employing [retrospective autoethnography] did not anticipate participation in the said event with an intention to engage in research around it" (2022, p. 2). This fact disadvantages RAE researchers somewhat since they are not able to thoughtfully prepare research questions prior to undergoing their experience, nor are they able to engage in a systematic gathering of data or coding themes in real-time, or even prepare ways in which to supplement their data (such as with interviews). Instead, they must rely on other mechanisms for which to re-gather, re-analyse, and re-interpret this data. I do not use formal interviews, however; this does not mean that I did not speak (at length) with colleagues about our shared distress at the time – or that I have not sought information on occupational stress since (e.g., articles, publications, books). I have spent great lengths of time engaging in hundreds of conversations with colleagues about the nature of our workplace, related both to its challenges and mundane moments.

Some memories were seared into my memory because of the emotional impact they had on me. Consider the following two examples:

> I stood beside the patient's bedside in the ICU and watched as the family gathered around them to visit. I was collecting my data, with half my attention on my work, and half an eye on the family. Just then, one of the family members who had just pulled up a chair took out an acoustic guitar with a multicoloured strap. She tenderly brushed the patient's hair out of their eyes and said, "I'm going to sing for you like I always do." I thought about how sweet that was as they started to play; she sang, "*All my bags are packed, I'm ready to go,*" she strummed softly, "*I'm standin' here outside your door, I hate to wake you up to say goodbye…*" She sounded like there were now tears in her eyes. She continued, "*But the dawn is breakin', its early morn, the*

> *taxi's waitin', he's blowin' his horn. Already I'm so lonesome, I could die. So, kiss me and smile for me, tell me that you'll wait for me, hold me like you'll never let me go...* I began to feel the emotions welling up inside of me, as her voice intensified, "*'Cause I'm leavin' on a jet plane, don't know when I'll be back again, oh babe, I hate to go.*" I could no longer hold back my own tears, as they streamed down my face. I stood very still for a moment, to honour that patient who I knew was going to die, then I wiped my tears off carefully and went to the restroom to remove all evidence of my emotional outburst.

> It was a day like any other, I went about my business as usual to collect patient data, chat with colleagues, and prepare my work for the next day. Until suddenly, everything changed. Without notice, I heard the loud whaling sound of a siren that took *everyone* by surprise. I was used to patients crying at the bedside, but this was entirely different. It was the unique sound of a mother in distress… having just lost her teenage boy to a traumatic accident. The physicians had just declared him dead. I walked over closer to the bedside to make sure everything was okay and to see what all the commotion was about. Just then, I watched as the mother screamed in agony and fell to her knees as if in prayer, with tears falling to the floor as she screamed again, "No, why god no, no, NO!!!!!" Incoherent words could be heard in between her gasps and screams… as she choked on the pain… she was inconsolable. I stared in disbelief, the pain now settling deep inside of my own heart as I watched her melt onto the floor of the ICU, surrounded by nurses and doctors who knew they simply had to allow her this moment.

Other memories were simple and mundane, but I remember them because they had cognitive importance to me, in other words, they were formative for my learning in the hospital. They were moments that reminded me to always question the simple things, and to care about how patients were being supported by me even in my limited role.

> My colleague looked at me and asked, "Hey, can you please ensure that you always tell anaesthesia when you book a CABG?" "Sure," I replied, "What's a CABG?" I asked. He looked at me and said, "Hmm, good question, I've never asked." "Oh – why not?" I said, almost laughing. "I don't know, I've never thought to," he said smiling. "I presume it's not a cruciferous vegetable?" I said laughing even more… "Hey Nancy," I said to the charge nurse, "What's a CABG?" Nancy turned around to say, "It stands for coronary artery bypass graft… it's an open-heart surgery," she then swivelled back around in her chair to focus on her assignments. "Oh great, thank you!" I replied. My colleague agreed that it was good to know. I thought to myself, if I was going to be responsible for getting the right surgical equipment

> prepared for a patient, especially in emergency situations, I should be confident about what body part is going to be operated on.

These are the types of details that stick out in my mind, some of them happened long ago, and others were more recent. The last example would have happened during my first week of training in the operating rooms. Not all my memories are this clear, but the ones that were formative for me as a professional (and as a person) *are* distinctly memorable. My memories from working in the ICU are even more clear since I was still working with this group when I began the early stages of formulating this research project. I mention the possible variation in my memory because the retrospective autoethnographer must face the general question of credibility when it comes to reporting on their data. Some argue that "the application of RAE is challenging due to inaccurate recollection of past events, selective analysis of memories, change of attitude during the study, and lack of consent from participants;" and even that this type of work can be "biassed, narcissistic, and generally lacking rigour and a scientific slant" (Tripathi et al., 2022, p. 2-3).

However, it is important to remember that *everyone* has a particular point of view when experiencing events or when answering research questions, and no matter the individual – every participant risks the possibility of being imprecise, inaccurate, or incorrect. Research participants are also not immune to personal bias. Rather than consider the retrospective autoethnographer uniquely inadequate, I will instead argue that there are specific benefits as well as drawbacks to engaging in the practice of RAE compared to other qualitative research that seeks to gather multiple perspectives (e.g., retrospective collaborative autoethnography (RCA) which attempts to avoid this pitfall by harnessing information from multiple autoethnographers together). I argue that the retrospective autoethnographers use of a more in-depth process to engage with understanding people, beliefs, customs, and events as they are experienced in real-time; by using a lengthy, systematic, and reflexive approach to re-gathering and re-analysing data, they can develop a deeper and richer database from which to derive meaning.

The supposition with retrospective analysis seems to be that recollecting personal data is difficult; however, this assumption does rely on certain presumptions like the presence or absence of barriers that might affect the process of recollection, such as how long ago the events took place, how good someone's memory is, and/or how carefully the person was paying attention at the time (what their focus was), and/or the cognitive lens(es) that person used to process the events of interest. Concerning the timeframe, if a researcher is still quite immersed in their research area of interest, or if the event itself was not very long ago, recalling specific details of that event may not be difficult at all. Some researchers may have an excellent memory, they may have journaled the events or were so traumatised by the event that the scenario was imprinted onto their brain. There are many possibilities. Arguably, full immersion in, and great attention to the details of a cultural experience will surely provide a more accurate depiction of a culture than a random sampling through survey questions. Someone who equally lives the life of participants has a type of familiarity and knowledge that cannot be gathered through brief interviews alone.

Since we have already outlined many of the drawbacks, let us consider some of the benefits. Benefits to conducting a retrospective analysis include (1) it is "a serendipitous opportunity to discover new knowledge, given that not only the research topic is decided post-events, but researchers are also potentially experiencing the event that happens not in the same place and/or at the same time," (2) "the reflexive material of the [autoethnographic] researchers can be argued to be more organic and freer from bias as the researchers are less involved in the activity, making it easier to look at it from the outside with a better cultural perspective" (Tripathi et al., 2022, p. 2), and lastly, (3) contrary to a more traditional qualitative study that might rely on gathering information (from insiders) at a single point in time, such as through the administration of a one-time survey, or through conducting a short series of focus groups over a month, the autoethnographer can gather thousands of hours (or years) of personal data in situ. Those involved in RAE, having been insiders previously, had the previous virtue of questioning, engaging in conversation, sharing one's thoughts and feelings, as well as bonding through adversity over the years as a member of the team.

1.3.2 Data Collection

The data collection process involved becoming refamiliarized with memories from my memory bank, a personal repository of sorts that has stored all my experiences in the hospital over the years. Some of these memories are so vivid that I can play them back like movies, others I only remember bits and pieces of. To recollect them, I would engage in a process of focused recall, where I would bring myself back to a particular memory, e.g., the day when I broke up with my boyfriend and had to get through the busy OR day without crying, and then start to replay the events, the sights, the sounds, and smells. The monotony of certain events also stuck with me, such as booking patients for surgery, taking phone calls, bringing case carts to the OR theatres, pulling my scrubs out of the Scrub-x machine, or walking through the hallways of the hospital. These daily events tended to blend, creating a blur of similar imagery and sensations that were so familiar they became automatic. I was also a creature of habit, as they say, and I liked my routine. I generally took the same pathway into the ORs every day, following my own ritualistic method for preparing myself for the job.

> Walking up to the scrub machine, I dug around in my backpack for my ID badge. Scanning the machine, it spat out a blue pair of tattered scrubs from the bottom door. I saw that one pocket of the pants was hanging on by only a thread. I contemplated throwing them back into the dirty scrub machine and scanning the clean dispenser for another pair – in hopes of getting a more intact outfit for the day – but I decided there were no holes anywhere and

that they would suffice. The older scrubs tended to have a softer, more comfortable fabric anyway. Swinging around to the entrance of the OR, I scanned my ID badge again to walk into the department. Walking past the laundered warming gowns and the disposable hats and booties I took the door on the right to enter the women's change room. Neatly putting my OR clothing in a pile on the wooden bench between the lockers, I undressed. Pulling my blue scrubs on over my head (which sometimes took a little bit of shoulder dislocating) I managed to get the scrub top down past my arms and tuck it into my pants. I tied the bright blue string tight around my waist and began to gather all my hair in my hands to tame it into a loose bun. Tucking my hair inside my black cloth OR hat, my favourite hat which had printed white magnolia flowers on it, I put my mask on over my mouth and the loops around my ears. Putting the nose of my glasses over the mask, I slipped into my OR shoes and covered myself in a warming gown. Grabbing some essentials from my bag I looked for ways to disperse them among my various pockets, placing my cell phone into my back pocket and my ID badge in my front pocket along with my credit card and lip gloss. Exiting the changing room, I navigated the various hallways that made their way towards the 'inner core' of the operating rooms, as a friend yelled out, "Nice flood pants, girl!" joking with me that my OR pants were so short they looked like I was preparing for a flood. Dashing around the corner, I arrived just in time to greet the charge nurse, the clerical staff (who was waiting to change shifts with me), and the other various OR staff who were congregating in the inner core office space. The phone was ringing off the hook, so I grabbed some medical-grade wipes to clean my workstation before I could complete a handover conversation with my colleague. Logging into my hospital programs (e.g., for booking surgery, registering patients, printing paperwork, finding surgery codes, ordering surgical case carts or equipment) the phone continued ringing, as I leafed through the surgical cases for the day to determine whether it was going to be a stressful day. "Only three lap-appy's," I said, "Not bad at all!" – referencing that only three patients were waiting for an appendectomy, a sure sign that things were pretty calm… for the time being.

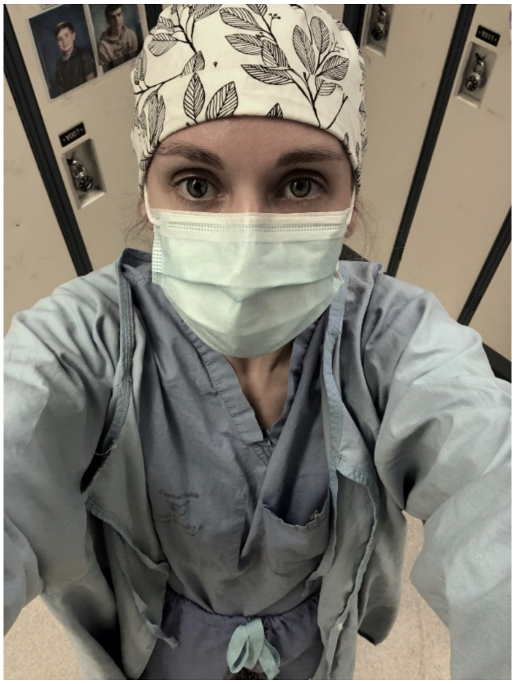


Figure 5: Dressing for Work in the Operating Rooms, Self Portrait (2022).

I was just as ritualistic with my ICU work, arriving at the same time each day, determining how many patients were admitted, carefully filling out my paperwork, and then grabbing my computer to visit each patient and nurse at their bedside. The events that I participated in every day were routine and easy to remember because I had completed them thousands of times; but so were the events that were not part of my routine, because they stuck out as novel or noteworthy. When looking to recall certain events, I would walk myself through my daily routine and then catch myself noticing the memorable parts of the building, such as particular rooms where specific events took place, or items that had meaning seared into them, such as a particular case cart for open-heart surgery or the CRRT machine. This imaginary walk through the operating theatres or the ICU would bring up all sorts of memories and feelings, which I would then feel into as much as possible, allowing my memory to flood with the experience once again. Once I had fully absorbed myself in the memory, I would write it down. Later on, after some time away from the memory, the passages would be re-read and scanned for keywords, salient feelings, thoughts, and meanings.

I also kept records of certain events in the form of personal journaling and notes, as well, I took academic notes related to my preliminary preparations for conducting research. I only began the process of taking notes approximately ten years into my hospital career, so the memories recorded in my journal and my academic notes are more recent. My journals mostly contained thoughts and feelings around significant events, such as being scolded or embarrassed, yelled at, witnessing something gruesome, or situations that felt unjust. I was always very focused on the ethical nature of the medical units I worked in, and when I witnessed a patient being harmed by the process of care, or intentionally by someone who was not looking out for their best interests, I would remember these events and ruminate on them for days afterwards. I once overheard an anesthesiologist coaching a young resident on how to bill for the most hours possible during labour and delivery in obstetrics.

My academic notes were primarily focused on solving the puzzle of occupational stress. I would jot down significant features of the workplace in the form of anonymous unfinished sentences, such as, "Futile care and balancing family and patient autonomy with physician and nurse autonomy," "Identity prejudice for patients in the ED," "Surgeon argues about wearing Covid-19 personal protective equipment," and lastly, "Nurse cried today after not receiving a break for hours… the pandemic exposes the lack of foundation and the overburden already present." These phrases were meant to trigger those ideas in my mind again and were noted so that I would further engage with the "problem" later. My notes allowed me to reconstruct visual and emotional memories and further reflect on them, a practice that may have benefitted me earlier on in my work-life since journaling can be highly therapeutic. I also engaged in purposeful or deliberate recollection of events, where I would mine my memory for details of the context, sensations, and emotions of the past.

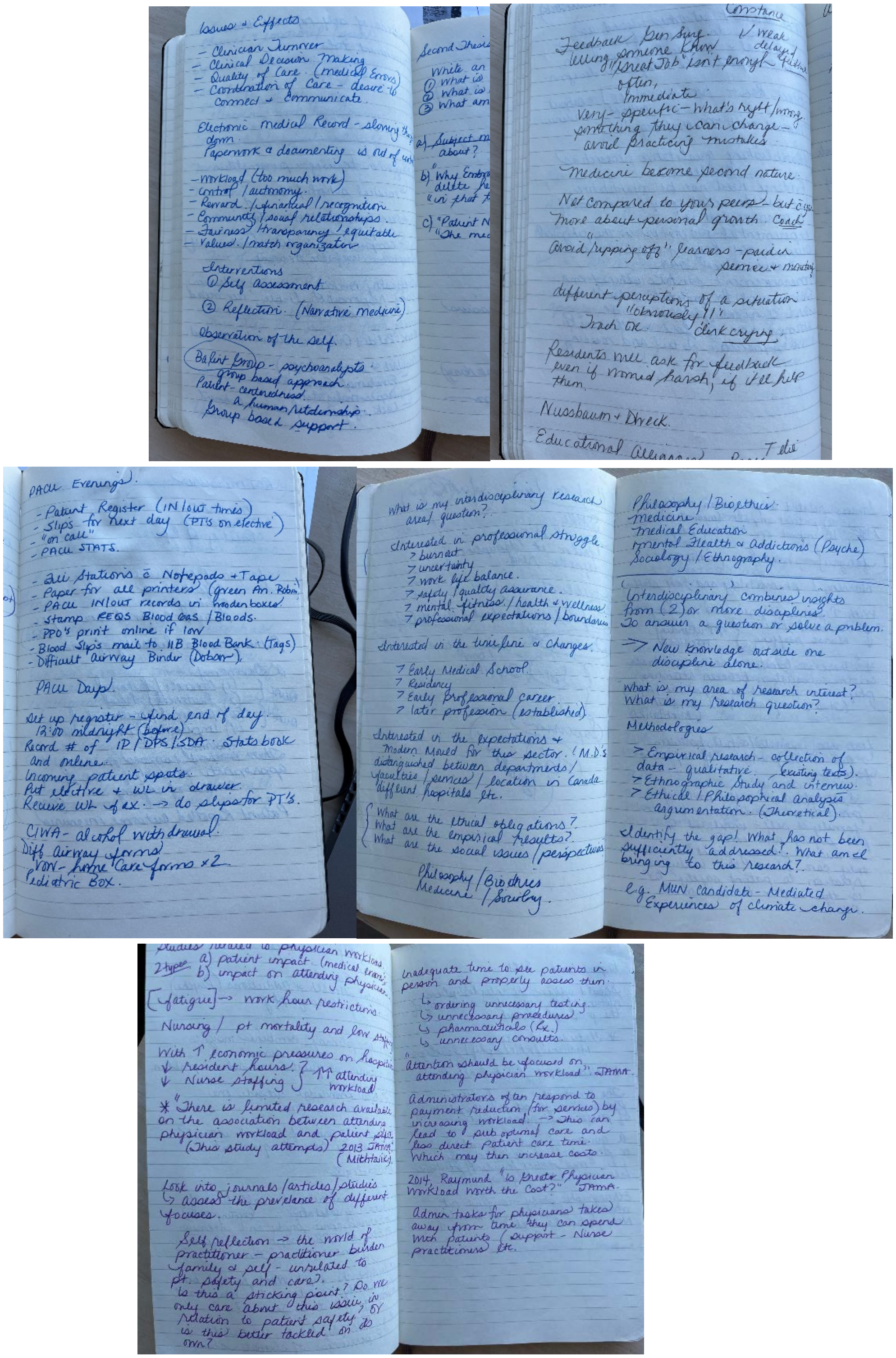
Since I have always been very observant of my surroundings, I can often recount situations and conversations more clearly than the information I might read in a book or hear about in a story, since the information was sensory and experiential. However, I do note that my memories will not be perfectly reliable, and of course they will always be from my own perspective. I also engage in retrospective observations and reflections that focus on other people, as well as texts, images, policies, and structural data from the hospital (architecture, social settings, or physical spaces) that are both publicly available (hospital buildings, public-facing materials, or cafeterias, etc.) and privately secured (e.g., restricted access to internal policies, emails, meeting materials) that I experienced as an employee. Our processes in both the OR and the ICU were always very structured, and there was almost always a policy, protocol, document, or pre-printed order (PPO) for everything that I used at work (e.g., surgical booking forms, or critical care nursing flow sheets). We also have routines and tacit ways of *being* on the units that were second nature to me, so I later had to critically engage with my habits instead of taking them for granted.

The process of collecting data for this project was by no means straightforward, however, I did try to follow a general process. My process focused on two primary modes of data gathering, (1) remembering as much as I could about the past through what I will call deliberate, structured recall, and (2) reflexively engaging in self-examination and self-study to uncover how my experiences relate to the broader cultural context of critical care (and perioperative medicine). Once most of my experience had been catalogued and categorised, I needed to start making sense of the stories, the imagery, and the words themselves. I would often get down on the floor with large pieces of paper to begin writing my general ideas. At first, I would simply write keywords, such as "burnout," "tired," "unhappy," "futile care," or "bullying." Soon, these words would become phrases, e.g., "burnout relates to exhaustion, depersonalisation, and reduced personal accomplishment," or "when staff call in sick, it's often for mental health reasons, not due to physical illness."

Later, phrases like this, and individual words would be circled with bright-coloured markers as I discovered the family of concepts each one belonged to, or I would hypothesise what the connections were, e.g., Is burnout an illness, a phenomenon, or a workplace hazard? As I stared at the words on the page, I would mentally lump various data into related families, for instance, I would ask myself, what do 'burnout' and 'moral distress' have in common? Are they both labels for fatigue or exhaustion and the associated feelings that come with those experiences? Or are they unique? Were they merely presented in the same literature searches and were common to the medical field? I would define terms through the existing literature, such as providing a dictionary or scholarly definition of burnout and moral distress, and I would reflect on what these experiences felt like in person. I have experienced both burnout and moral distress personally in the hospital, and therefore, I could cross-examine the reports in the literature with my own personal data.

The practice of writing down my thoughts and beliefs on paper (repeatedly) allowed me to play around with the data in various ways, to see it in a new light each time I revisited it, often making new connections and making sense of what I was seeing and feeling, as I gave the data new labels and searched for novel ways to accurately describe the nature of these experiences (see Figure 6 as an early example of this process, taken from my Master's work). Early on, I would pour through my notes and visual memory to create maps of data, which grew over time to become spiderwebs of interconnections and relations. Once I had a large enough set of data, or I had sufficiently recaptured the salient details of my years in the hospital, I then had to decide what data was relevant and what data was irrelevant. In the beginning, all of the data seemed relevant to me, since I had yet to make sense of it. In order to focus my attention and narrow my scope, I engaged in a process of reflecting on experiences that triggered emotion. I utilised emotional sensations and emotional memories as a key for targeting important data.

This led to general categories like "abuse," "support," "acceptance," "confusion," or even "anger," "sadness," "grief," or "power" and "powerlessness" all of which also had to be placed in a particular context, such as "while helping patients," "while talking to staff," "while feeling ignored," "while noticing injustice." Experiences that triggered very little emotion were still examined, however, these experiences seemed to only provide a foundation for the context of this research (e.g., the details necessary to understand the setting, the ICU). In other words, the emotionally neutral experiences were often related to routine, protocol, and monotony; whereas the highly emotional experiences were often where there were ethical dilemmas, difficult experiences, traumatic scenarios, and conflict in the workplace. Since our focus here is on occupational stress and emotional labour, the majority of data relating to stress, distress, or emotional hardship are very relevant to answering the research question.



Issues & Effects

- Clinician Turnover
- Clinical Decision Making
- Quality of Care. (medical Errors)
- Coordination of Care - desire to connect + communicate.

Electronic medical Record - slowing things down.
Paperwork & documenting is out of order

- Workload (too much work)
- control / autonomy.
- Reward. / financial / recognition
- Community / social relationships.
- Fairness / transparency / equitable
- Valued. / match organization

Interventions
① Self assessment

② Reflection. (Narrative medicine)

Observation of the self.

Balint Group - psychoanalysts.
group based approach.
Patient - centeredness.
a human relationship.
Group based support.

Second Thesis
Write an
① What is
② What is
③ What am

a) Subject m
about?

b) "Why Embra
delete he
"in that t

c) "Patient N
"The med

Constance

Feedback Gen Surg. ✓ weak
delayed
letting someone know
"Great Job" isn't enough
often,
Immediate
Very - specific - what's right / wrong.
something they can change -
avoid practicing mistakes.

Medicine become second nature.

Not compared to your peers - but c̄ you
More about personal growth. Coach

Avoid "ripping off" learners - paid in
service + monetary

different perceptions of a situation
"obviously!!"
Trach OR. clerk crying.

Residents will ask for feedback
even if worried harsh; if it'll help
them.

Nussbaum + Dweck.

Educational Alliance T die

PACU Evenings.

- Patient Register (IN / OUT times)
- Slips for next day (PT's on elective)
- "on call"
- PACU STATS.

- All stations c̄ Notepads + Tape
- Paper for all printers (green An. Robin)
- PACU IN / OUT records in wooden boxes.
- stamp REQS Blood Gas / Bloods.
- PPO's print online if low
- Blood slips mail to 11B Blood Bank. (Tags)
- Difficult airway Binder (Dobson).

PACU Days.

Set up register - find end of day.
12:00 midnight (before).
Record # of IP / DPS / SDA. Stats book
and online.
Incoming patient spots.
Put elective + WL in drawer.
Receive WL fax. → do slips for PT's.

CIWA - alcohol withdrawal.
Diff airway forms
VON - home Care forms × 2
Pediatric Box.

What is my interdisciplinary research
area / question?

Interested in professional struggle.
> burnout
> uncertainty
> work life balance.
> safety / quality assurance.
> mental fitness / health & wellness
> professional expectations / boundaries

Interested in the timeline & changes.

> Early Medical School.
> Residency
> Early Professional career
> later profession (established).

Interested in the expectations +
Modern Model for this sector. (M.D.'s
distinguished between departments /
faculties / services / location in Canada
different hospitals etc.

What are the ethical obligations?
What are the empirical results?
What are the social issues / perspectives

Philosophy / Bioethics
Medicine / Sociology.

Philosophy / Bioethics.
medicine
medical Education
mental Health & Addictions (Psyche)
Sociology / Ethnography.

Interdisciplinary combines insights
from (2) or more disciplines.
To answer a question or solve a problem.

→ New knowledge outside one
discipline alone.

What is my area of research interest?
What is my research question?

Methodologies

> Empirical research - collection of
data - qualitative. (existing texts).
> Ethnographic Study and interview.
> Ethical / Philosophical analysis
argumentation. (Theoretical).

Identify the gap! What has not been
sufficiently addressed?. What am I
bringing to this research?

e.g. MUN candidate - Mediated
Experiences of climate change.

Studies related to physician workload.
2 types a) patient impact (medical errors)
b) impact on attending physician.

[fatigue] → work hour restrictions.

Nursing / pt mortality and low staffing

With ↑ economic pressures on hospitals
↓ resident hours.
↓ Nurse staffing } ↑↑ attending workload

* "There is limited research available
on the association between attending
physician workload and patient safety.
(This study attempts) 2013 JAMA
(Michtalik).

Look into journals / articles / studies
↳ assess the prevalance of different
focuses.

Self reflection → the world of
practitioner - practitioner burden
family & self - unrelated to
pt. safety and care?.
Is this a sticking point? Do we
only care about this issue, in
relation to patient safety, or
is this better tackled on its
own?

Inadequate time to see patients in
person and properly assess them.
↳ ordering unnecessary testing.
↳ unnecessary procedures
↳ pharmaceuticals (Rx.)
↳ unnecessary consults.

"Attention should be focused on
attending physician workload". JAMA.

Administrators often respond to
payment reduction (for services) by
increasing workload. → This can
lead to sub optimal care and
less direct patient care time.
Which may then increase costs.

2014, Raymund "Is Greater Physician
Workload worth the Cost?" JAMA.

Admin tasks for physicians takes
away from time they can spend
with patients (support - Nurse
practitioners etc.

Figure 6: Series of Journal Entries Showing Early Thoughts About the Medical World– "Notes on Healthcare," 2018 onward.

The above series of journal entries is an example of early data (generated approximately between 2018 and 2020) where I would jot down general concepts such as the disciplines I felt were relevant for my work e.g., medical education and sociology; I would consider related concepts of "stress" such as "increased economic pressures," "fewer staff," and "higher workload," in medicine; as well, I took some notes when working on different units (e.g., the above entry is when I began working in a new PACU). Unfortunately, I did not capture photos of all the notes, reflections, and musings I had over the years; however, they all looked quite like these entries. Sometimes they would be written on scraps of paper that I would shove in my scrubs pocket, listed in the note's application on my iPhone, or simply remembered inside of my mind. I also utilize 'photovoice' at times, as some of the images included in this project were taken by me in the hospital (See Figures 3.0, 4.0, 5.0, and 8.0).

Once I had generated a large degree of reactions and emotions for various types of situations I experienced throughout the years, I then began imagining what the core features were of various pairings of the data. For example, I might ask myself – what do "sadness" and "while being ignored" have in common? This is when I began to generate preliminary themes, such as "belonging" or "feeling accepted," as well as noting how these words/phrases related to a person's sense of self or identity. This methodical way of processing years of stories and information was very helpful for me, and as you will see in later chapters, a lot of my resulting themes did end up corresponding with key topics in contemporary literature on occupational stress and medical burnout.

After the organisation process was complete, and I had successfully derived various data points from my own experiences, which included material facts, subjective thoughts, feelings, and self-understandings. These datapoints were then listed as 'corresponding to specific stories' or narrative text (held within the greyed-out text boxes in this project). As you might imagine, I had recalled and recorded a significant degree of experiences, memories, thoughts, and feelings, so the next challenge was deciding what should be included in the final dissertation material. My focus was indeed on experiences and memories that showed "distress" in healthcare, in other words, that depicted my struggles, doubts, concerns, and run-ins with non-empathetic providers, careless people, and unaware groups of individuals, as well as difficult patient situations. I included some stories that were more positive, however, the stressful experiences were directly related to answering my research question, and thus, were considered important for my review. Lastly, I wanted to systematically and formally analyse this data using thematic analysis which is discussed in section 1.3.3.

1.3.3 Data Analysis

While the retrospective autoethnographic process has its own methodology, which was discussed in section 1.3.1, I decided to explore other complementary ways to analyse the data I had gathered, which is not uncommon for autoethnography.

> "Autoethnographers often rely on various methods of data gathering and research tools common to other forms of qualitative social research, including participant observation, interviews, conversational engagement, focus groups, narrative analysis, artifact analysis, archival research, journaling, field notes, thematic analysis, description, context, interpretation, and storytelling. They then craft compelling narratives that attempt to evoke and capture the lived experiences of the researcher (and coparticipants, as applicable) in relation to the phenomena under study. Most autoethnographers take a multipronged, layered, hybrid approach—drawing on various methodological tools common in qualitative inquiry—as they research social phenomena and craft compelling narratives about human social or cultural phenomena" (Poulos, 2021, p. 5).

Since this project is interdisciplinary, I purposefully used a hybrid approach when conducting this research. I focused on several methods and theories including completing a self-study, undergoing a critical and reflexive analysis of that study, processing the data and analysing it using the method of thematic analysis, as well as further layering feminist and ethical lenses (or theory) over the data to enrich the analysis. By examining the data from multiple perspectives with various tools, a researcher is then able to gain further insight into the data, which ultimately should help generate meaning and significance around that data. Once these data points were on the table, and after a preliminary investigation into the trends of the data, thematic analysis was then utilised to organise this data into meaningful categories and themes.

Once a sense of the categories/themes was developed, higher-level theory was then used as a way to further interrogate these themes and the meaning that they are given throughout the broader literature. The core high-level theories that support this argument come from relational care ethics, Marx's concept of alienation and Arlie Hochschild's understanding of emotional labour (each topic will be covered in its own chapter). These theories align with the broader themes I have derived from my data, which layer onto my analysis of these phenomena. The use of mixed methodology is not essential for this work, however, the frameworks, methods, theories, and various ways of thinking about data have all been highly effective and helpful for me throughout the execution of this research.

Similar to grounded theorists, who recommend that researchers look to their own data for inspiration, meaning, and emerging trends before doing a literature review, I focused strictly on my own data investigation prior to diving more deeply into the literature. Glaser and Strauss, famous for grounded theory, have even "explicitly advised against conducting a literature review in the substantive area of research at an early stage of the research process: 'An effective strategy is, at first, literally to ignore the literature of theory and fact on the area under study'" (Glaser & Strauss, 1967, as cited in Dunne, 2011, p. 113). Dunne writes that "This stance directly contradicts most methodologies, which view a detailed literature review as an essential foundation upon which to build a study" (2011, p. 113-114). The goal is to gain a perspective that is "uninhibited by extant theoretical frameworks and associated hypotheses" (Dunne, 2011, p. 113-114). Once I was able to see the emerging themes in my data, I then looked back at the literature to determine the salience of what I was discovering. My data is meant to be reflective of a local setting and a particular division of medicine, therefore, it was important to me to look at the data with fewer expectations around what I might see.

Now that I have generally laid out the methodology and plan for data analysis, I will provide more detail about the process of using thematic analysis. Thematic analysis (or TA) is often credited to authors and psychology professors Virginia Braun and Victoria Clarke who popularised this concept in "Using Thematic Analysis in Psychology" published in *Qualitative Research in Psychology* in 2006. Since then, they have written at length on the subject, both refining and broadening the concept of TA as what they argue "is better thought of as a family of methods" (Braun & Clarke, 2023, p. 1). TA is a qualitative research tool and "method-ish," as Braun and Clarke say, that can be utilised to assist researchers in processing their data using semi-structured 'ways' of analysing, such as coding, to identify what can be understood as "themes" in the data.

Braun and Clarke want users of TA to be aware of its flexibility and the diversity of approaches to the methodology, which include *reflexive* TA, a term they now use (Braun & Clarke, 2022a, p. 4). They explain that similar to how Kathy Charmaz (2014) and Glaser and Strauss (1967) "reworked grounded theory into a reflexive, constructionist approach, from earlier iterations with a foot- or toehold in positivism" they regard their methodology in the same way, as "valuing a subjective, situated, aware and questioning researcher" (Braun & Clarke, 2022a, p. 5). Braun and Clarke want researchers to be aware of what they are doing when they choose TA as a data analysis tool and method, and how they should "recognize the plurality of TA," determine one's own values and assumptions, as well as be able to justify when multiple approaches or "mash-ups" are being used, as well as any divergence from established practices of TA (Braun and Clarke, 2023, p. 4). The authors say:

> "In pointing this out, we're not arguing that analytic procedures should be followed precisely like baking recipes and that this is what constitutes good research. Rather, a knowing TA researcher would acknowledge their divergence from established procedures, including conceptual incoherence, and provide a rationale for their innovative approach. It's not the case that "anything goes" in TA research, as the procedures have broad paradigmatic and conceptual foundations. Researchers cannot coherently be both a descriptive scientist and an interpretative artist (Finlay, 2021). The procedures we and other TA methodologists have developed are thought-through manifestations of underlying research values, meaning divergences and mash-ups should be equally thoughtful" (Braun & Clarke, 2023a, p. 2).

Reflexive thematic analysis (RTA) is a term that Braun and Clarke now use to explain how they approach TA, which is to encourage reflexivity in the approach, that is, a process that considers the influence of the researchers' analytic preconceptions by "interrogating what we do, how and why we do it, and the impacts and influences of this on our research" (Braun & Clarke, 2022a, p. 5). Paul

Lichterman also says that “ethnographers perform reflexivity by discussing how their research may reflect interests or biases that accompany their positions in hierarchies of domination” (2017, p. 35). RTA researchers must examine their choice of research questions, their targeting of communities, the methodologies, and ways of engaging with the data. Braun and Clarke acknowledge that there is a large degree of subjectivity involved with this, yet these are decisions that are made by all researchers without such a high level of reflection. The goal of analysis through TA (i.e., the interpretation process that is conducted by the researcher) is not to be accurate and objective, but instead, as Braun and Clarke argue, interpretations of the data can be either “stronger” (i.e., “compelling, insightful, thoughtful, rich, complex, deep, nuanced”) or “weaker” (i.e., unconvincing, underdeveloped, shallow, superficial) (2022b, p. 9).

All of this is very similar to what reflexivity means for ethnographers, as Braun and Clarke guide ways to navigate this process, which include being aware of one's subjectivity, taking care in the coding process, avoiding “positivist creep,” and ensuring that themes are not just “summaries of everything” but more “analytic outputs” that do not passively emerge, but instead, are “actively produced by the researcher through their systematic engagement with, and all they bring to, the dataset” (Braun & Clarke, 2022b, p. 9). Therefore, themes do not emerge from the data randomly, rather they surface as the researcher engages with the data in their attempt to answer the research question. Data is a broad term and can include texts, narratives, memories, images, feelings, thoughts, pictures, expressions, and so forth. Once data has been collected, the researcher should first familiarise themselves with it before engaging in further steps like coding (Braun & Clarke, 2006).

Braun and Clarke note that “what different versions of TA share is an interest in patterns of meaning, developed through processes of coding” (Braun & Clarke, 2022b, p. 8). Braun and Clarke say that “a code is the smallest unit of your analysis” (2022a, p. 52), which is the starting point for the research (after observations have been made) and is how one processes the data. “Your codes form the building blocks of your analysis” and from these, the researcher goes on to develop themes (Braun & Clarke, 2022a, p. 52). Coding takes place by reducing the data into smaller and smaller categories that seem to share meaning, where the researcher is then eventually able to discern the themes or trends within the data as they form patterns of significance (Braun & Clarke, 2019). These themes will need to be named as they constitute relevant and distinct categories of the overarching theory, which are derived from having coalesced the findings. The authors also emphasise that we should “reject the notion that coding can ever be accurate—as it is an inherently interpretive practice, and meaning is not fixed within data” (Braun & Clarke, 2023, p. 2).

This process further includes self-reflective analysis on “ways of doing things” or habitual “ways of being” for myself – such as repetitive or predictable habits of action (e.g., handwashing more often, if a germaphobe), degrees of comfort (e.g., fear of invasive medical procedures, or being conservative with one's clothing), levels of tolerance (e.g., intolerance to loud noises or yelling), or tendencies towards behaviours (e.g., extroversion versus introversion). This methodology (i.e., reflecting, coding, analysing, re-coding, thematic analysis, etc.) is designed to pull out meaningful categories of stress in an *inductive* way, whereby, rather than first generating a hypothesis which is then tested via data collection, data is collected initially and then analysed to inform and generate a theory.

The experience of determining the salient themes within my data set was quite rigorous and took years to accomplish. From the outset of drafting a general research topic in 2018 to formulating a research question, and designing the autoethnographic method for examining this question, I have engaged with what I will call general themes for the last six years. At first, there existed both large and small 'themes,' in other words, some were obvious themes which were being pushed into the data (like "burnout" or "compassion fatigue"), terminology that was so present in the medical world that it was almost impossible to not look out for their presence; whereas, smaller themes were those that I included as hunches that arose from my own experiences, such as "being bullied" or "excessive workloads," themes that felt obvious to insiders.

I then underwent "an iterative process where data collection and analysis occur[red] concurrently: insights emerging from early data [which would] shape further data collection, which in turn add[ed] to [my] existing understanding, and so on until 'saturation' occur[red]; that is, no new insights emerge[d] from further data collection" (Al Chapman & Chapman, 2015, p. 202). In my case, I did not collect new data, but I would revisit existing data and reflect more deeply on my experiences until it felt like I had finally made sense of them. The raw data collected in this study generated various codes and resulting themes that are felt to be importantly connected to both personal and workplace wellbeing (See Appendices 1 & 2).

I have added two tables (Appendices 1 & 2) for reference, which provide various samples of the coding process, to help orient the reader to this process. Initial coding looked something like this: I would review a passage of notes, or a visual memory (which had been written down as an exercise in remembering) which would be engaged with to determine meaning. I might take a passage that describes being ignored by a colleague and consider codes around "silencing," "oppression," "hurt feelings," "sensitivity," and so forth. Similarly, other passages may receive codes but may turn out to have no apparent relevance to the research question. In this case, they did not end up in the final themes of this project. Coding is viewed by Braun and Clarke as "a *subjective* process" shaped by what the researcher brings to it, who subjectively fuels the process of *interpretation* and meaning making (Braun & Clarke, 2022a, p. 55). We can imagine a researcher who may have coded the experience of being ignored more externally, as "rudeness," instead of coding it to reflect an internal state, e.g., "hurt feelings."

After all the codes were analysed, engaging with possible themes was the next stage. "A theme captures the *patterning* of meaning across the dataset" and "for reflexive TA, a theme has to capture a wide range of data that are united by, and evidence, a shared idea, sometimes quite obviously, and sometimes far less obviously, and sometimes in quite different ways" (Braun & Clarke, 2022a, p. 76-77). Braun and Clarke also differentiate – for researchers who want to use TA properly – between what they call "topic summaries" (or what we might envision to be "buckets" of similar data, according to Clarke) and proper themes, which are more conceptual "because they dig down below the surface meaning, and are united around an idea that isn't necessarily obviously evident in the data" (2022a, p. 78). Theme development and coding also go through many phases of analysis, re-analysis, and re-re-analysis to ensure consistency and rigour in the process.

For a closer look at the data coding process, respectively, Appendices 1 & 2 outline: (1) the qualitative analysis process (having undergone retrospective self-reflection, drafting narrative data, coding the data, and conducting a thematic analysis) as well as (2) the six core themes that were derived from the data, which include: identity as a means of belonging; awareness of the self and others; emotional work and labour; relational security, trust and integrity; alienation from the self and the production of one's labour; and lastly, care work as a means of oppression. These themes were realised through a continuous and reflexive process of coding narrative data, re-coding narrative data, and then immersing oneself in the relationships between various coded data, and lastly, producing labels for groups or families of data, which ultimately were compared with the literature.

To further explain this process, let's consider the example of alienation. The word 'alienation' was not recorded by me or said by me in the initial data-gathering phase. Instead, the raw data was rough and took the form of descriptive words and experiential language, e.g., "hungry," "low energy and tired of not having fresh food in the cafeteria late at night." This rough data was then allotted to a general category, which may have changed over time and reassessment, e.g., "displeasure," "non-caring institution," or "lack of awareness of what staff need." Once these general categories were formed, and they were sufficiently saturated with data, in other words – once I had recollected and organised all of the data that I could adequately capture – it was then time to reflect on these categories. I would engage visually with lists of these categories filled with corresponding lists of data points, and I would then look for relationships and shared meanings within them.

To determine the shared meaning between being hungry at work, feeling like there was no access to food at work, and feeling upset that my institution did not care enough about me to provide healthy food in the workplace, I needed to look for shared frameworks (e.g., the supporting or basic structure of my categories) and cross reference any potential frameworks with similar data points and shared categories. Some potential frameworks for the above data points could be "neglect," "lack of resources," "food as a low priority for the hospital," "disillusion with the institution," or "alienation." Once it was clear that a particular framework was fitting, in other words, it was able to adequately explain and connect data points with a reasonable degree of continuity and consistency, the overall themes began emerging. Alienation is a theme that seemed to fit well with many data points, for example, those related to labour (both market labour and emotional labour) and a caregiver's connection to the production of their labour which connects strongly to the themes of care ethics (and relational feminist ethics). This process was repeated for each set of data, and then the resulting themes were examined multiple times over.

The primary themes that emerged from the data and through my process of data analysis include (1) awareness, (2) identity, (3) integrity, (4) alienation, (5) emotional labour, and (6) care. These six themes, or what can also be understood as general frameworks for our understanding, were derived as titles for what had been expressed most prominently in the narrative data, in other words, these were the subject matters that arose from the various data points. Each resulting theme will be discussed in the following chapters. Many of the sub-themes – those that are *not* discussed in their own respective chapter (e.g., integrity, trust, values, silencing) – have been subsumed under the larger core frameworks since they represent related concepts, e.g., we can imagine how 'caring well' will include fostering trust, maintaining integrity will require being clear on one's values, and lastly, that silencing is a mechanism that contributes to alienation.

The six core themes will be anchors for our understanding of occupational stress in critical care medicine, and together they provide us with language to help us understand the forces that influence one's ability to navigate stressful situations. All these themes will be explored more deeply throughout this project; however, I will give special attention to four core themes: awareness, identity and integrity, emotional labour, and care ethics/work which will form the basis of later chapters. Having derived these themes throughout the data analysis process, I later assessed and compared these themes to local and international data (e.g., articles, publications) and theories that related to each theme in Appendix 2. Importantly, these themes are not summaries of what I have experienced, which could easily be explained by topic headings such as "working in medicine is exhausting," or "medicine is a difficult career choice;" instead, the core themes listed above are analytic outputs, they were actively created by me as the researcher (Clarke, 2021, 26:53). Victoria Clarke says that:

> "Theme generation occurs – at the intersection of the data, the researcher's interpretive frameworks, their training, their skills, their assumptions, and so on. So, they're things the researcher builds or creates through their interpretive engagement with data, they're not things that pre-exist the analysis. This is another really important distinction to hold on to whether you're conceptualizing themes as buried treasure (that would emerge from the data) or whether you're seeing them as things that you create as a researcher" (Clarke, 2021, 26:56).

The above themes tell stories and are multifaceted, they also reveal some of the underlying assumptions about medical life, while conceptually revealing the potential blockages to dealing with stress in medicine.

1.4 Relational Themes

The six themes – awareness, identity, integrity, alienation, emotional labour, and care – all represent *relational* categories between the self and one's professional world (Sherwin, 1985). The concept of relational categories materialised organically throughout the research process, however, my labelling of these categories as 'relational' is indeed taken from the work of Susan Sherwin – who produced "the first dissertation in the United States on the ethics of feminism" and who "sparked the new field of feminist bioethics," publishing in 1992 her powerful book *No Longer Patient: Feminist Ethics and Health Care* (Hunter, 2018, para. 4 & 5). Sherwin engaged critically with traditional masculine moral theories of her time by pointing to their problematic abstraction from actual human persons and their relationships with one another; she writes:

> "The moral theories that derive from the principle of abstraction are excessively individualistic. They rest on a model that views persons as autonomous, normally isolated atoms. Occasionally, one bumps into some other atom and moral principles are designed to govern behaviour in the essentially deviant circumstance that obtains when these independent individuals meet. Individual rights and autonomy are given priority in this model, and attention is focused on protecting each individual from excessive bumping by others. It is seen as important to present and entrench the fierce independence of each person. Such a view makes social interaction an anomaly to be treated with suspicion. Most moral theories in fact seem to view social interaction in just this way. Obligations do not direct one to seek out interaction with others, to strive for cooperative arrangements, but rather to refrain from interfering excessively with the independence of some other person one might happen to bump into.
>
> At the same time, the traditional theories are depersonalising in a serious way, since they urge us to formulate rules for relating to other persons which must be valid for any meetings with any other persons; we are to generalise by abstracting as far as possible from the details of the particular situation. Kantianism in particular urges us to disregard any special relations between oneself and the person in question. Sentiments relating to the other person are said to be quite irrelevant from the moral point of view. Morality is to be concerned with duties towards persons qua persons, not to specific persons in terms of social and political facts" (Sherwin, 1985, p. 705-706).

The dominant view of moral and political theories of the time focused strongly, and without much awareness, on the perceived or assumed virtues of the "non-emotional," the absence of "personal feelings," or the potential threats related to "communities" of individuals (Sherwin, 1985, p. 707). Sherwin writes "The result is that our feelings are officially denied and dismissed and the practices that oppress women continue" (Sherwin, 1985, p. 708). Sherwin's focus on a feminist ethical approach helps us reimagine what would matter for persons who have long suffered oppression (via race, class, gender, etc.) and bring to the public's awareness how "the currently popular moral theories are inadequate to express the moral intuitions upon which feminism rests" (Sherwin, 1985, p. 712). She argues that "It is time to follow through with the logic of feminism to develop a moral theory compatible with the moral experience of women and the political ideals of feminism" (Sherwin, 1985,

p. 712) which "cannot simply be mapped onto the existing moral theories because there is disagreement with the fundamental ontology of the dominant moral theories" (Sherwin, 1985, p. 708).

Like Sherwin's assessment of the abstract and oppressive nature of moral theories, the various themes that arose from my own raw narrative data point to both personal and institutional ways of being in medicine that may not be compatible with physical, mental, emotional, or psychological health for all. Joan Tronto, a political moral philosopher, also makes this argument when she discusses "bad care" with Todd May on his YouTube channel *The Philosopher* (2023). Tronto gives the example of wealthy parents who want their children to attend a "good school," and to achieve this they decide to move out of an area that is filled with "crappy public schools" (10:24). Tronto explains how "that's a kind of care, you're caring for your own kids, but it's also a bad care, and if we live in a society where everybody's decisions about care are based on the kind of individualistic decisions about what's good for us, the end result is a really uncaring society" (10:32). It can also be "directed towards the good of another or a group" but it's still bad care (11:15). She suggests a way to mitigate this is to have a feedback loop where caregivers and recipients of care can comment on the quality and type of care received, which is an aspect of *caring well* (a concept that will be further explored in Chapter 5) (The Philosopher, 2023, 11:28).

The above themes should be thought of as relational categories, in other words, these themes are not purely individualistic nor are they blind to the many oppressive and unjust ways of operating in the world. Instead, these themes should be considered within an individual as well as within groups and subgroups. I specify that the themes should be considered both for individuals and groups because individual persons cannot learn to act in ways that are caring and just towards others if they refuse to look at the nature of their own thoughts, feelings, and behaviours. How individuals and organizations can take responsibility for occupational stress will be discussed more in later chapters, and as we move into Chapter 2, we will first discuss how stress affects critical care staff before we explore the themes more deeply.

To summarise, in this chapter, I have recounted my own experience with trauma and stress in my personal life and the workplace; I have explained the purpose of this project, which is to use personal experience and narrative data as a means to better understand occupational stress in critical care medicine; I have situated myself as the researcher (as having bias, positionality, history, and various predispositions and prejudices); I have explained the interdisciplinary nature of this research project, while outlining the methodology, theory, and hybrid model of data collection and analysis (i.e., the use of retrospective self-study, critical theory, reflexive analysis, and thematic analysis); and lastly, I presented the overarching themes that were generated from my data collection and analysis. Chapter 1 covers a lot of ground, setting us up nicely for the information presented in subsequent chapters. In Chapter 2, I will discuss why occupational stress is problematic for medical staff, what contributes to occupational stress, and the types of syndromes and disorders that can result from prolonged stress and the effects this has on a person’s mind, body, and psyche.

Chapter Two

Orienting Us to The Problem

2.1 “Stress” in the Helping Professions

Stress, if we imagine it for a second as an entity of its own, does not limit itself to particular areas of care necessarily, nor is its impact restricted only to particular sets of caregivers, such as brain surgeons or life-flight crews. Instead, stress can follow medical staff and patients anywhere they go, meaning a person can work in a range of locations, whether in an eye clinic, the emergency bay, or the ICU, and still be exposed to stressful or traumatising events at *any* time. I recall working in the ICU one day when a patient died suddenly in an outpatient clinic nearby where they had only undergone a simple non-invasive exam. This was considered to be a place where death is *never* expected to occur, a fact that made this patient’s death more intensely distressing for the staff working there. We have also had patients go into cardiac arrest in the pre-operative waiting room, hours before they were scheduled to have surgery.

Both *acute* and *critical* care environments – respectively, areas in hospitals that deliver either the “necessary treatment for a disease or severe episode of illness provided for a short period of time” (CIHI, 2023) or care for patients “who have life-threatening injuries and illnesses” (Christensen & Liang, 2023, p. 406) – are expected to undergo stressful events more frequently, and are thus acknowledged to be prone to high levels of stress, described as “a state of worry or mental tension caused by a difficult situation” (WHO, 2023). In the hospitals where I have worked, critical care staff were often expected to better handle these situations compared to caregivers who worked in less critical areas. An example of this, from my own experience, is when a patient was close to death in the operating room, and the staff decided to call the ICU expecting to transfer that person before they died. In the eyes of the surgical team, the ICU is a much better place to die, where family can be at the bedside and trained staff are there to help a patient pass away. However, from the perspective of ICU staff, it can sometimes feel as though every dying patient is handed off to them, disrupting the continuity of care, and greatly increasing their exposure to, and responsibility for all end-of-life care.

The exact distinction between “acute” and “critical” care medicine will occasionally be important for this project, so I will bring our attention to this now. The definitions are not always straightforward, since critically ill patients can have acute crises and receive acute care; this ambiguity is evidenced by authors Christensen and Liang who write in their 2023 publication “Critical Care: A Concept Analysis” that critical care may refer to two things: “one is the function of a dedicated, specialist team of health professionals to support and care for the critically ill person during a medical emergency or crisis, while the other is a dedicated location where this focused care is undertaken" (p. 403-404). This lack of clear delineation also applies equally to the concept of acute care, which may depend either on the type of care being provided (e.g., stitching a wound versus administering resuscitation techniques), or the location in which the care is given (e.g., an ophthalmology clinic versus the emergency department).

For our purposes here, let us use the definitions initially provided above, which delineated acute care as a treatment that is delivered for severe episodes of illness over a shorter period, and critical care as a treatment that is delivered for life-threatening injuries or illnesses potentially for a long period, or until recovery or death. Recovering from surgery is a good example of acute care, where a patient is treated briefly for an underlying illness, injury, or disease and they are then discharged shortly afterwards; whereas critical care, which can also be understood as a treatment that is provided to patients who are admitted to and cared for in an ICU, often requires intense and aggressive care (e.g., cardiopulmonary resuscitation (CPR)), or long term treatments that are life-saving, often invasive, and require huge investments of resources, time, and effort (e.g., prolonged intubation with a feeding tube).

Critical and acute care areas of medicine both deal with acute (or intense) medical crises, and they also deal with chronically ill patients who may be experiencing an acute (or worsened) period of decline. Providing critical or acute care can be highly stressful. The stress experienced by caregivers when delivering medical care can be episodic (i.e., presenting as short or localised events) and/or chronic (i.e., long-term and pernicious). What is unique about acute or critical care medicine is that the crises patients face within these areas of care are so commonplace that the stress of dealing with extremely ill patients tends to be chronically experienced by these providers. This makes these care areas prone to what can be understood as chronic *occupational* stressors or high levels of job-related stress. As one might expect, occupational stress can lead to stress-related conditions such as chronic exhaustion, hypertension, major depression, or even post-traumatic stress.[19]

Exposing caregivers to frequent stressors – especially stressors that caregivers do not know how to effectively stave off or deal with – will put them at a higher risk of experiencing deteriorating health, mood, and productivity, which can further lead to the delivery of poorer medical care by disordered

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[19] Throughout this project I will refer to specific terms used in clinical psychology and psychiatry (e.g., post-traumatic stress disorder, clinical depression, dissociative disorder) but it is important to note that I am not a qualified mental health specialist nor am I a diagnostician. I will not be discussing the physiological or psychiatric conditions of persons who have been diagnosed with mental illnesses as classified by the DSM-V, nor commenting on the different health histories of persons. Instead, this conversation is meant to indicate that symptoms, syndromes, and diagnoses that have been diagnosed by external mental health specialists can arise in healthcare settings (given the diverse population) and I will cite evidence that suggests there is an increased risk of mental illness, i.e., psychological stress, and psychological crises, in acute care given the high exposure to trauma, death, and dying.

caregivers. [20] Evidence shows that the effects of occupational stress are not limited to clinical staff alone, as Dazu and colleagues report “not only are clinicians’ lives at risk, so is patient safety” (2018, p. 312). They also report that “some studies have revealed links between clinician burnout and increased rates of medical errors, malpractice suits, and healthcare-associated infections” and that “in one longitudinal study, the investigators calculated that annual productivity loss in the United States that is attributable to burnout may be equivalent to eliminating the graduating classes of seven medical schools” (2018, p. 312).

It is important to note that many authors use the term ‘burnout’ as a catch-all to describe the physical, mental, and emotional stress facing healthcare providers today. However, according to Christina Maslach, a lead researcher on the syndrome, the term “burnout” is quite specific and strictly refers to how someone is simultaneously (and sufficiently) exhausted, cynical, and feeling a sense of reduced personal accomplishment (Maslach, Schaufeli & Leiter, 2001). Maslach’s definition, which outlines what she has dubbed burnout syndrome (BOS) later inspired the World Health Organisation (WHO) to add burnout to the International Classification of Diseases (ICD) in 2019. Similar to Maslach’s definition, the ICD defines burnout as “a syndrome conceptualised as resulting from chronic workplace stress that has not been successfully managed. It is characterised by three dimensions: feelings of energy depletion or exhaustion; increased mental distance from one’s job, or feelings of negativism or cynicism related to one's job; and reduced professional efficacy” (ICD, 2022).

If caregivers are not helped to manage their stressors in healthy ways, they will resort to more direct ways of avoiding/coping with stress, such as avoiding the work, avoiding the job itself (e.g., calling in sick), internalising/externalizing stress, and eventually, leaving one’s career and profession entirely. Between 2020 and 2021, The Canadian Institute for Health Information (CIHI) reported that “there were almost 500 fewer RNs in direct care employment in long-term care (2.2% decline) and over 100 fewer LPNs in direct care employment in community health agencies (0.8% decline)” (2022). On January 16th, the Canadian Broadcast Company (CBC) reported that “vacancy rates for registered nurses, licensed practical nurses and nurse practitioners are as high as 80 per cent at some Nova Scotia hospitals” (Seguin, 2023), a problem that has continued to grow. The Covid-19 pandemic truly emphasised how “health care workers are the foundation that keeps our healthcare systems running” and that “without them, there is no system to deliver care” (CIHI, 2022). We will always need healthcare providers in some fashion, meaning, a baseline understanding of the nature of stress that caregivers experience can help administrators, politicians, and fellow caregivers to reverse the harmful effects of unresolved occupational stress.

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[20] Disordered, as defined by the Oxford English Dictionary is “suffering from an illness or condition that disrupts normal physical or mental functions” (2023).

I – the researcher – have personally witnessed what I perceive to be burnout (and other responses to stress) in my local hospital setting for many years and having extensively researched these phenomena on the ground and in the scientific literature over the last five years, I have learned that burnout is only one aspect of, and one term for, occupational stress responses. Burnout exists on a spectrum of various other reactions to stressors (including personal, mental, social, psychological, spiritual, and environmental stress) all of which exist and operate in the workplace. Reactions to stress can vary, as will the intensity of the stressor, the frequency of it, and the duration one is expected to be exposed to high levels of stress; thus, reactions sit on a spectrum and include everything from minor annoyance to exhaustion alone, apathy, anxiety, clinical depression, trauma reactions, or suicidal ideation, to name a few. Many of these reactions, like the "canary in the coal mine," do point to a system that is putting too much pressure on its workers, a factor that is well-examined by many researchers.[21]

> It was late in the afternoon; I was working in the operating rooms and a level 1 (or STAT) patient was arriving for emergency surgery. Minutes earlier, I had taken the phone call to learn that it was a crush injury, in other words, a large fork-lift had fallen onto the patient, literally crushing their body, and causing severe damage. As I approached the OR suite to bring patient labels and to ask if the blood had arrived, I watched as the team attempted to hold onto the patient's bloody arm, which was just barely attached by a few tendons and bone, to position them on the table. There was so much blood that the patient's arm slipped out of the hands of one of the assistants, splashing blood all the way from their midsection to their feet. They hastily grabbed the arm and continued to hold it steady, while the surgeon assessed the damage. I thought to myself, it looked like it had gone through a meat grinder. The patient had a multitude of other injuries to their feet, abdomen, and their other arm, but I glanced back frequently to the arm that was mangled, to try to put it together in my head, to comprehend what had happened. At the same time, I made sure to look busy, as if I was not really staring at this horrible injury, as if I was not stunned by the situation, and as if I felt nothing. I knew, that's what you are supposed to do.

2.1.1 Getting Clear on Terminology

Throughout this project, I will use multiple descriptors to talk about the various *stress phenomena* that happen in everyday life as well as those that propagate in medical settings, some of which will have distinct meanings and others that may cross over into the territory of closely related

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[21] For a selection of articles that point to the harmful systematic effects of healthcare institutions, see: Wilkinson, et al., 2017; Rushton, 2018; Hancock & Witter, 2019; Seo, 2021; Epstein, 2021; Magner, et al. 2021; De Hert, 2020.

concepts (for instance, those that share similar symptoms, etc.). In this section, I would like to provide clarity around some of the terms that can and will be used to discuss occupational stress and the ways in which these terms are used to describe how stress affects people mentally, physically, and emotionally. I cover a lot of terms in this chapter, including the causes and effects of stress (e.g., headaches, fatigue, or moodiness), the syndromes, disorders, and illnesses that can emerge due to stressful experiences (e.g., anxiety, depression, PTSD), and the phenomenological experiences that can emerge under long term stress (e.g., moral distress, dissociation, or burnout). All these categories are connected, yet each term also holds a specific meaning and even though there are relationships between these terms, they are not all applied in the same way. In this chapter, I would like to be clear about their differences and their similarities.

The literature on ‘occupational stress’ (OS) is broad, and when you search this term specifically the results tend to populate a range of discussions around stress in the workplace that reference various circumstances and types of occupation. Occupational stress simply refers to stress that happens in the workplace, or within the setting or context of one’s occupation, and “is the condition in which workers see the job demands as stressors which exceed their coping ability, and thus trigger negative responses” (Souza, Silva, & Alves de Sousa Costa, 2018, p. 493); whereas stress is “any physical or mental pressure, or cumulated pressure, caused by stressors which destabilise individuals” (Souza, Silva, & Alves de Sousa Costa, 2018, p. 493).

OS represents a constellation of factors and potential symptomatology, causes, and disorders, including but not limited to chronic fatigue, tension headaches, and work-related injuries. As well, it represents how the poor management of staff, toxic relationships between colleagues, and inadequate support or a lack of resources, can all affect a person’s stress levels at work. Other literature focuses on specific phenomena that may contribute to, or develop from OS, including examples such as burnout, distress, moral distress, moral injury, moral residue, suffering, trauma, lack of resilience, mental health disorders/illnesses (i.e., anxiety, depression, post-traumatic stress, secondary traumatic stress, peritraumatic dissociation), or overall unwellness. Let us examine the differences between some of these key terms. [22]

Trauma, & Trauma Informed Care (TIC)

‘Trauma’ itself refers to “an emotional response to a terrible event like an accident, rape, or natural disaster. Immediately after the event, shock and denial are typical. Longer-term reactions include unpredictable emotions, flashbacks, strained relationships, and even physical symptoms like

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[22] By “other literature,” I am referring to all of the references cited in this project's bibliography that reference the terms listed in this section of the chapter, including all authors who refer to the different occupational stress related phenomena, e.g., burnout, moral distress, resilience, post-traumatic stress, etc. (see Freudenberger, Maslach, Schaufeli, etc.).

headaches or nausea" (Rowell & Thomley, 2013), "as well as uncontrollable thoughts about the event, intrusive memories, avoidance, negative changes in thinking and mood, and changes in physical and emotional reactions" (Mayo Clinic, 2022). 'Trauma-informed care' (TIC) is then a practice that recognizes the potentially traumatic life experiences of individuals. TIC describes the individual, professional, and systematic recognition of the past traumas that people have faced and requires careful attention to be paid to the needs of traumatised persons, as well as an effort to avoid re-traumatisation of these persons (Greenwald, et al., 2023, p. 3). "TIC acknowledges pertinent [personal] history related to past or current traumatisation in assessment and plan of care, while trauma-denied care ignores such pertinent history," meaning, "trauma-informed practices should be considered universal precautions and can be modified to work within [any organisation]" (Greenwald, et al., 2023, p. 3).

The literature related to trauma and trauma-informed care (TIC) is very applicable to healthcare distress and the mental health of caregivers. Trauma can be experienced by anyone, be it individuals alone, persons/groups, or even historically by large masses (e.g., the harms done to Indigenous and Black populations). Further to this, "Traumatic events can include both impersonal trauma (ecological events such as hurricanes, tsunamis, and landslides), or interpersonal traumas (events between people, such as child neglect and abuse, intimate partner violence, sexual assault, and human trafficking)" (Greenwald, et al., 2023, p. 2). Another important factor is that "those who experience interpersonal violence, especially those who experience violence over time (rather than a one-time acute event), tend to show worse long-term outcomes" and "the literature also shows that for survivors of interpersonal violence, the closer the person who inflicts the violence is to the survivor, the more impactful the event (for instance, stranger assault vs. assault by a family member)" (Greenwald, et al., 2023, p. 2).

Bessel van der Kolk, psychiatrist and author of the book *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*, writes that "while we all want to move beyond trauma" when it is experienced, "the part of our brain that is devoted to ensuring our survival (deep below our rational brain) is not very good at denial. Long after a traumatic experience is over, it may be reactivated at the slightest hint of danger and mobilise disturbed brain circuits and secrete massive amounts of stress hormones. This precipitates unpleasant emotions, intense physical sensations, and impulsive and aggressive actions" (2014, p. 2). He also discusses in his book, in a section labelled "speechless horror," how difficult it can be for trauma survivors to articulate and describe their experience to others, often being left momentarily mute or unable to formulate words (p. 43-44). Trauma memory, for van der Kolk, is different than our normal memory of events, and can be difficult to access or come racing back to us unannounced if suddenly triggered (2014, p. 44-55).

A trauma-informed lens is useful for understanding occupational stress, and I believe TIC is necessary for dealing with providers in acute and critical care areas of medicine where distressing medical events are common. One must be cognizant of the many overlapping experiences people have endured, and the types of stress, distress, residue, injury, trauma, burnout, and an array of mental health factors that may arise for individuals when they are put into situations that stimulate specific triggers, reminders, or stressors. Importantly, caregivers working in critical care are not able to run away (i.e., engage in their fight/flight tendencies) as facing difficult situations is part of their job. Van der Kolk discusses how "if the fight/flight/freeze response is successful and we escape danger, we recover our internal equilibrium and gradually 'regain our senses.'" However, "if for some reason the normal response is blocked – for example, when people are held down, trapped, or otherwise prevented from taking effective action… the brain keeps secreting stress chemicals, and the brain's electrical circuits continue to fire in vain" (2014, p. 54).

Post-Traumatic Stress Disorder (PTSD)

'Post-traumatic stress disorder' (as it is known in The Diagnostic and Statistical Manual of Mental Disorders (DSM-V)) requires a person to be "psychologically injured by a traumatic event," an injury that later causes "adverse long-term changes in emotion, thinking, and behaviour" (Leblanc, 2020, p. 17-18). PTSD is a mental health diagnosis that can occur for a person who experiences trauma or a traumatic situation and who is unable to bounce back from this event and continues to experience problems daily (such as anxiety, fear, depression, etc.). According to the National Institution of Mental Health (NIMH), to qualify as having PTSD, "a person must have symptoms for longer than 1 month and the symptoms must be severe enough to interfere with aspects of daily life, such as relationships or work. The symptoms also must be unrelated to medication, substance use, or other illness" (NIH, 2023).

Moral Injury

'Moral injury' is thought to be "the distressing psychological, behavioural, social, and sometimes spiritual aftermath" of a person's exposure to being complicit in or witnessing "behaviours that go against an individual's values and moral beliefs" (Norman & Maguen, 2021, para. 1). For instance, "…people may perpetrate, fail to prevent, or witness events that contradict deeply held moral beliefs and expectations, [leading to feelings of] guilt, shame, disgust and anger" (Norman & Maguen, 2021, para. 2). Consider the example of a nurse who must continually care for a patient who seemingly wants to die, but who cannot indicate their wishes using speech, writing, signs, or signals. Every day the nurse must wash them, treat their wounds, suction their endotracheal tube, and watch as their eyes indicate horror or may tear up in response to pain, but there is nothing the nurse can do, they must continue to care for the patient. This belief, that they are torturing the patient, may make them feel that they are going against a deeply held personal and professional value, i.e., to help the patient feel safe and cared for. Going against this value can be morally distressing, and eventually become morally injurious over time.

A good example of closely related terms is moral injury and post-traumatic stress disorder (PTSD); these two conditions share many of the same symptoms (e.g., nightmares, flashbacks, constant worry, and tension) despite being distinctly labelled phenomena – one is a mental health disorder (PTSD) and the other is not. So, how do you tell the difference? Whether or not a person is viewed as having a moral injury versus PTSD may depend on the context in which someone is being assessed (e.g., in a psychologist's office versus within an ethics consult), the individual making the assessment (i.e., their credentials and training), as well as the nature of what led to the feelings of distress or mental disquiet. There are clinical criteria, such as what is listed in the DSM-V, which can be used to assess a person's tendency for "re-experiencing, avoidance, negative cognitions and mood, and arousal" (APA, 2013) that define PTSD more formally, however, not every individual will fit into a neat and tidy box respective to diagnostic categories. Instead, some patients may exhibit features of PTSD, but will not fit all the criteria, meaning they will not obtain an official diagnosis. They will only have "traits" of PTSD but may still suffer in similar ways.

These individuals may also have very well undergone morally injurious events before receiving their clinical diagnosis, or on top of it. Williamson and colleagues (2021) write that "an individual's experiences of potentially morally injurious events can cause profound feelings of shame and guilt, and alterations in cognitions and beliefs (e.g., "I am a failure," "colleagues don't care about me"), as well as maladaptive coping responses (e.g., substance misuse, social withdrawal, or self-destructive acts)." They further write that "It is these challenged beliefs and altered appraisals that are thought to lead to the development of mental health problems, with a 2018 meta-analysis finding that exposure to potentially morally injurious events was significantly associated with post-traumatic stress disorder, depression, and suicidality" (p. 453-454).

Moral Distress

A term that has come up often in my bioethics work and research (alongside burnout) is that of 'moral distress', which refers to the distressing feeling of *knowing* what the right thing to do is but being prevented from acting on that knowledge. The source of this moral tension or conflict is understood as the constellation of stressful feelings that arise because of this, due to "institutional or internal constraints" (Ulrich & Grady, 2018, p. 1). A person may instinctively feel what the "right" thing to do is, but then feel upset when they are prevented from acting "rightly." The root of this unsettling or awful feeling is due to being forced to compromise on one's values, as well as to go against one's moral instincts, which over time erodes a person's sense of *integrity* or wholeness. From what I have witnessed, caregivers are commonly made to compromise their integrity, which strongly contributes to their overall allostatic load of moral distress and eventually, injury.

Consider the following example of a person who holds the specific value that ‘lying is wrong’, no matter the circumstance. One day, a circumstance arises that requires this individual to lie, no matter their belief. In this situation they may feel powerless to uphold their value (i.e., to not lie) and will feel internally conflicted as they are forced to make this choice, ultimately, going against what they take to be right. This can leave a person feeling guilty, like they have done something wrong; upset, as they were made to break their moral code; as well as unwell, due to the common physiological responses that arise for distressed persons, such as headache or nausea, etc. Moral distress is a major contributor to stress in healthcare, especially in areas like critical care, and the continuous erosion of integrity affects one’s professional identity, passion for their work (and confidence with which to do it), as well as their ability to feel things in a healthy way (especially if dissociation or depersonalisation is occurring in response to repeated moral distress that has gone unaddressed).

Moral Uncertainty

Moral uncertainty is another factor, whereby clinicians or nurses do not know what the right choice is for a particular patient. Factors that contribute to uncertainty at the bedside include increased comorbidity (having simultaneous medical conditions or diseases) which makes patients harder to treat. Patients who are suffering from many ailments may require invasive or risky treatments or complex long-term interdisciplinary care. Ethical conflict also contributes to uncertainty, and is driven by the complexity of healthcare institutions, the growing complexity of healthcare delivery, and the inconsistencies that arise from having specialised and siloed care that is not always holistic, comprehensive, or appropriate (e.g., futile care).

Moral Residue

Related to moral distress, ‘moral residue’ refers to the accumulated effects of unresolved moral distress; in other words, how the harmful effects of moral distress act on a person over time, having gone untreated or having been unaddressed for a long period, causing increasing amounts of internal moral harm. As stated above, moral injury is a related term that refers to the harmful effects of being exposed to morally damaging experiences, such as witnessing “acts of disproportionate violence” or “failing to report an event that violates rules or ethics” (Norman & Maguen, 2021). Moral damages are a serious matter because these forces deeply affect a person's sense of self, safety, integrity, and wholeness.

Sanctuary vs. Sanctuary Trauma

I will also mention the concept of “sanctuary trauma” here, although it will not be discussed within the themes later, it is a factor that I want us to be aware of since (1) many of my arguments propose that hospitals are not always safe places to process emotion, (2) critical care units should provide their caregivers with a form of sanctuary, which is where my recommendations come into play at the end of this project. The Sanctuary Model – which originated in Philadelphia in the 1980s – was "created by a team of clinicians working in a small inpatient adult hospital unit. This team, led by Dr. Sandra Bloom, combined their clinical knowledge with their own experiences to create a trauma-informed program they called Sanctuary" (Sanctuary Institute, 2024).

The purpose of the Sanctuary Model is to guide others on how to implement effective clinical and organisational changes for patients and people by promoting "safety and recovery from adversity through the active creation of a trauma-informed community" (Sanctuary Institute, 2024). Dr. Bloom uses the word sanctuary "To describe a place where injured people – and that includes all of us in some way or another – are able to heal through the supportive care of others," she explains that "a sanctuary is a place of joy and creative innovation, of sympathy and solace, and transformation" (Bloom & Farragher, 2013, p. 1). For this reason, sanctuary *trauma* is when a person who has been traumatised seeks sanctuary, refuge, or safety (expecting to be accepted, supported, and healed) only to be exposed to further stress and trauma.

Burnout Syndrome (BOS)

Burnout is the syndrome that arises when workplace stress becomes unmanageable or is left unaddressed. Burnout – in my opinion – is the endpoint of chronic stress. It is an endpoint that people can be brought back from, but it is a critical stage of occupational stress whereby a person is failing to cope in healthy ways, they are checked out of their role, and they need help, usually in the form of an intervention (i.e., personal changes to support the self, or external resources that instil change for them).

The term 'burnout' is quite intuitive as it conjures an immediate sense of what is meant by its expression. Taken literally, burnout is the act of smothering a fire by removing the necessary resources required for it to burn (Schaufeli et al., 2008, p. 205). However, burnout as experienced by humans is often a very slow and cumulative process. So, rather than picture a mysterious force suddenly snuffing out a candle flame, we should instead imagine that a brightly burning fire is not self-sustaining and that external supports and conditions are required to fuel the combustion process. If there is not enough atmospheric oxygen or there is a barrier to accessing the open air the flame will eventually fizzle out. This analogy works well to portray individuals working within the "helping" professions, as many caregivers suffer burnout from a lack of physical and emotional resources required to do their jobs.

The word burnout has been used colloquially to mean a lot of things – namely, some degree of departure from normal health and happiness – and it is often used to simply mean exhaustion. Yet, after almost fifty years of examination and review, burnout 'proper' (according to leading scholars like Maslach) is specifically an *occupational* problem, meaning it is a phenomenon that is special to the workplace. This purposeful distinction by Maslach, the labelling of burnout as an occupational experience, does raise some questions about what it means to 'work' in medicine, and why this particular type of work so strongly affects people that they simply burn themselves out.

Other Terms (Secondary Trauma, Dissociation, Depersonalization, etc.)

Other terms will be used less frequently in this project, although, I will still define them here for context. 'Secondary traumatic stress' occurs when someone hears about someone else's traumatic experience or the primary traumatic experience of others. In this case, just knowing about or hearing the events of 'primary trauma' is enough to cause a trauma response in another person. It is critical to acknowledge how prominent secondary trauma may be, and it would be naïve to presume that the continuous treatment of traumatised patients (e.g., a patient who has self-inflicted gunshot wounds to their face, or was eighty percent burned) would not be a form of secondary trauma for the caregivers tasked with helping them to heal. 'Peritraumatic dissociation' is a coping strategy and reaction to experiencing trauma and stress which "is defined as a complex array of reactions at the time of the trauma that include depersonalization, derealization, dissociative amnesia, out-of-body experiences, emotional numbness, and altered time perception" (Thompson-Hollands, Jun, & Sloan, 2017, p. 190). Further to this, "several studies have found strong correlates between peritraumatic dissociation and posttraumatic stress disorder (PTSD) resulting from various traumas" (Thompson-Hollands, Jun, & Sloan, 2017, p. 190).

A major concern with dissociation ("disconnections between thoughts, feelings, behaviours, sensations, and other mental processes that would normally be connected" (Boyer, et al., 2022, p. 79)), and depersonalisation (feeling like you are outside of your body or that others around you are not real or meaningful) (Boyer, et al., 2022, p. 79), or with any coping strategy that occurs as a response to protect an individual from experiencing harm or trauma, is that "over time, and particularly in the context of repeated trauma during childhood, the use of dissociation can become a rigid and automatic response to stress that disrupts the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behaviour" (Boyer, et al., 2022, p. 79). While dissociative mechanisms are adaptive and are temporarily helpful to trauma victims in an immediate sense (e.g., during the trauma itself), this behaviour can be very damaging to these individuals eventually leading to health problems, difficulty in relationships, in the workplace, and with daily functioning.

Today, international research efforts focus heavily on a variety of what I will collectively refer to as occupational stressors or stress disorders, those that may refer to a constellation of stress responses, reactions, symptoms, and effects, such as burnout syndrome (BOS), which in 2021 "an international expert panel presented a consensual definition on burnout that reads as follows: 'In a worker, occupational burnout or occupational physical AND emotional exhaustion state is an exhaustion due to prolonged exposure to work-related problems'" (Schaufeli, 2021). Although not all physical manifestations of stress are disordered, and they may come and go for individuals, such as compassion fatigue, distress, insomnia, depression, and anxiety, all of which can increase in severity to the point where they become disorders, they need not advance to this stage. These types of stress have been reported by healthcare providers across the globe (Center et al. 2003), making healthcare institutions (e.g., hospitals, clinics, family medical practices) ideal breeding grounds for occupational stress disorders or "conditions arising from the interaction of people and their jobs" (Beehr & Newman, 1978).

Having now defined many of our terms, the reader should begin to see that there is a need for individuals and organisations (especially those that expose workers to consistent trauma and stress, e.g., accidents, disease, illness, death, or dying – such as healthcare institutions) to change the dialogue from "What's wrong with you?" to "What's happened to you?"

2.1.2 The Problem

> "In earlier times, illness was thought to result from the presence of a single pathogenic agent—germ, toxin, endocrine imbalance, vitamin, or nutritional deficiency, etc. New knowledge, however, has increased the recognition that the aetiology of poor health is multifactorial. For example, the interaction of the mind and body in the production of health/illness is being recognized increasingly and medical research and practice are gradually taking this into account" (Beehr & Newman, 1978, p. 667).
>
> "A second evolution in medical thought is the recognition of the broader, multidimensional environment as an important influence on health. For example, in addition to considering the interaction of psychological (mind) factors and physical (body) factors, there is increasing interest in the social environment as a very important determinant of health/illness. Many researchers are investigating stress as the primary social-psychological cause of heart attacks. Some, in fact, feel that stress may contribute to the development of all illnesses" (Beehr & Newman, 1978, p. 667).

The constellation of stressors that exist in healthcare – those which are liable to affect both caregivers and care receivers alike – are innumerable and ubiquitous. Some stressors are obvious, e.g., a patient who is coding in front of you, and others are more subtle, e.g., the constant ringing of the telephone in the background. [23] The emotions associated with stress will present in different ways for different people. For me, emotions were like apparitions, they did not overtly show themselves until

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[23] The term "coding" or "code" colloquially refers to when a patient is in cardiac arrest or is requiring cardiopulmonary resuscitation (CPR). Our hospital refers to this as a "code blue," an emergency code that alerts ICU staff to the critical status of a patient who is either on the floor of the hospital or somewhere else in the hospital (e.g., in x-ray). We thus have a "code team" that is responsible for going to these patients for resuscitation efforts. The code team is usually comprised of experts in either anaesthesia or critical care, critical care nurses, respiratory therapists, and/or residents who are on-call.

things had gotten very bad. You can imagine it being like in a horror movie such as *The Conjuring*[24] (2013) where the malevolent spirit is hiding most of the film, only presenting as noises, shadows, or moving furniture – which are always more subtle at first and build in intensity. In the end, the spirit's vengeful arrival then removes all doubt around their suspected existence, whereas before it was easier to explain away their presence (Wan, 2013).

> "I'm fine! I promise," I said. "You seem to be acting a little strange, are you sure you're okay?" my colleague asked me. "I am just feeling a little sensitive today… let's focus back on this patient," I replied. "Okay, if that's what you want," said my colleague. I went to the bathroom to cry… I thought, "I can't believe the doctor told me to shut up, that's such a mean thing to say to someone's face… I wasn't even talking that loudly," I reasoned with myself. I waited until the redness disappeared from my face, I dried my cheeks, blew my nose, and exited the bathroom to head back to the ICU. "Now, I can just ignore that person while I continue to do my work," I thought. "What's this person's diagnosis?" I asked my colleague who had joined me again, "Did they just get here from another hospital?" I said pretending to sound cheerful and normal. "Yes, they just arrived and will be going on CRRT, so you get to stay longer today!" My colleague feigned happiness and rejoiced. "Yay!" I said back to him, pretending to be okay. I sighed and continued to stare off through the glass window where they prepared the new patient for intubation. I smiled at my colleague and became quiet, pretending to focus on the data in front of me.

Emotions can be sneaky or unexpected if we ignore the signs. If we ignore them for long enough our bodies will try to tell us how stressed we are by making our emotions more obvious to us, meaning, they may increase in intensity. The above sample of text is an example of how I felt when I was talking to my colleague in the ICU and one of the staff scolded me for talking too loudly during morning rounds. This event was not as egregious as others I had experienced, although my emotional state was more fragile on this day, so I felt more offended than usual. I simultaneously felt feelings of shame, guilt, and disrespect, which culminated in tears. As I cried in the bathroom, I knew I needed to compose myself so they would not 'see me sweat', so to speak, a good example of repressing things. Who was I performing for? What is wrong with crying? What emotional rule was I abiding by? Why

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[24] The media streaming service Netflix © describes 'The Conjuring' as follows: "In 1970, paranormal investigators and demonologists Lorraine (Vera Farmiga) and Ed (Patrick Wilson) Warren are summoned to the home of Carolyn (Lili Taylor) and Roger (Ron Livingston) Perron. The Perrons and their five daughters have recently moved into a secluded farmhouse, where a supernatural presence has made itself known. Though the manifestations are relatively benign at first, events soon escalate in horrifying fashion, especially after the Warrens discover the house's macabre history" (2013).

did I not speak up for myself, or talk to the staff afterwards? These are questions that I would later have for myself.

My understanding of this event today is that I had so many repressed emotions at the time that the smaller things felt much larger than they were. In other words, by continually ignoring my feelings, I was becoming more and more resentful of mistreatment, injustice, and abuse. Some of my experiences could rightfully fall into the category of being abusive, such as being talked down to or sworn at, whereas others were more innocent, the doctor above was just asking for some quiet after all. These situations are as much about our perception and our own self-care emotionally as they are about what others do to us or say to us. Additionally, any habitual practices that people may/or may not have learned throughout their lives or have adopted in the workplace – e.g., behaviours that support the continued denial or repression of emotion – will affect our reactions. These behaviours further reinforce counter-productive behaviours that do nothing to help us feel better, like avoiding, withdrawing, lashing out, or blaming others. If our emotions are gently tended to, acknowledged, and accepted, either through psychological counselling or even trauma-releasing exercises (see Parker et al., 2024) it is believed that they can diminish and be released rather than be stored in our psyches and bodies.

Healthcare providers talk about how an illness will “declare itself,” in other words, it will progress to a point where it becomes clear what the ailment is, or that the suspected diagnosis is correct. Sometimes, if you leave things alone, they will make themselves known. Covid-19 was an interesting situation that brought global attention to how the mental health of caregivers was not in a good place, and the pressure of more patients was something hospitals clearly could not handle. The resulting after-effect of this brought caregiver emotion into the spotlight, however, beyond discussing the truth of the fact that caregivers were suffering from significant occupational stress, little has been done to combat the insidious nature of needing to ignore emotion when working in medical spaces or in front of other medical personnel. This chapter will outline the “problem” as I see it, or the present problem healthcare workers have been facing for years related to their psychosocial understanding of emotion as it relates to professional work, with attention paid to the general chronological sequence of discoveries about occupational stressors in Western societies.

West and colleagues wrote in *The Lancet* in 2016 that “physician burnout has reached epidemic levels” nationally in the United States (p. 2272). Hints of improvement were indicated in 2019 as Sara Berg (a news writer for AMA Physician Health) wrote that “for the first time since 2011 the physician burnout rate has dropped below 50 percent among doctors in the U.S.” (para. 1). This quote was taken from a study published in *Mayo Clinical Proceedings* which also found that “43.9 percent of U.S. physicians exhibited at least one symptom of burnout in 2017, compared with 54.4 percent in 2014 and 45.5 percent in 2011” (Shanafelt, et al., 2019, p. 1681). On the heels of this announcement, as Berg writes about physician burnout in February 2020, the WHO released a situation report that they had "increased the assessment of the risk of spread and risk of the impact of Covid-19 to very high at the global level" (WHO, 2020). On February 28, 2020, there were only 59 confirmed cases of Covid-19 in the United States and 11 in Canada. Little did anyone know that the effects of Covid-19 would shift burnout trends back towards critical levels not only in the United States and Canada but globally.

This means that before the Covid-19 pandemic (which began in 2019) occupational stress disorders such as burnout, high rates of attrition (or leaving the medical profession), and general unhappiness in one's medical career, were commonplace. Then, after the coronavirus left its mark on healthcare systems across the globe, things got much worse. Today, staggering evidence still suggests that a significant number of healthcare providers are burnt out or leaving their jobs or experiencing significant personal harms (e.g., chronic fatigue from overworking, cynicism or hopelessness, divorce, the effects of alcoholism, or drug abuse) (Hancock & Witter, 2019). [25] Individual researchers have become increasingly interested in measuring these phenomena (e.g., using surveys or interviews) to prove the existence of stress phenomena and the harmful effects of stress in the workplace, as well as to better target therapies (Maslach: 2001; 2012; 2015; 2018; 2020). Institutions, associations, and academies continue to acknowledge this as a difficult problem to solve.

Going back a few years, in January 2017, the National Academy of Medicine (NAM), the Association of American Medical Colleges (AAMC), and the Accreditation Council for Graduate Medical Education (ACGME) "launched a national Action Collaborative on Clinician Well-Being and Resilience" (Dzau, Kirch, & Nasca, 2018, p. 313). Within this initiative, NAM outlined four main goals: (1) to increase awareness of the existence of burnout; (2) to make organisations aware of the difficulties faced by clinicians and the potential risk to their wellbeing; (3) to find evidence-based solutions; and lastly, (4) to oversee the effectiveness of all proposed solutions (Dzau, Kirch, & Nasca, 2018, p. 313). Included in the response to this 'call to action' was a statement issued by the Canadian Medical Association (CMA) emphasising burnout as a "growing priority," including concern surrounding the health of Canadian institutions and their "long-term sustainability" related to burnout, and lastly, the need to promote physician health "as a core competency" (CMA, 2017).

Soon after, the Canadian Medical Association (CMA) National Physician Health Survey released survey findings in October of 2018 showing that approximately one-third of respondents were burnt out or depressed (CMA, 2018). They reported that "82% of physicians and residents reported high resilience" but also that "more than one in four reported high levels of burnout" and "one in three screened positive for depression" (CMA, 2018). Similarly, the 2018 Department of

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[25] For a selection of only a few references within a sea of academic articles and journalistic reports that outline the global impact of suffering (physical and mental) on healthcare staff see: CMA, 2017; CMA, 2018; Dzau, Kirch, & Nasca, 2018; De Hert, 2020; Magner, et al. 2021.

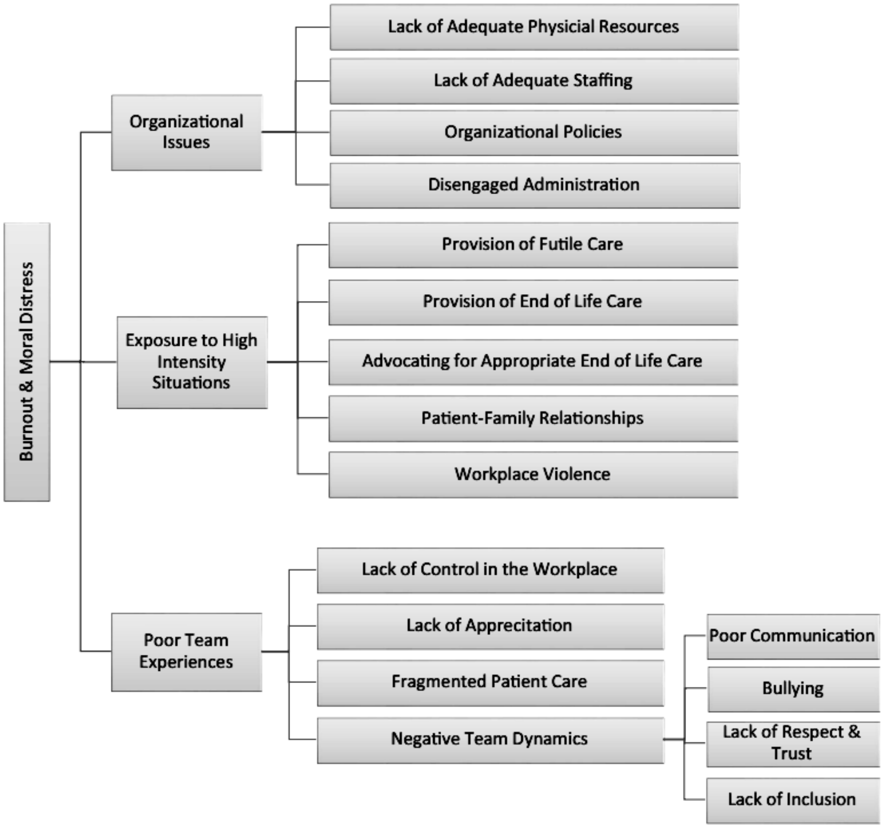
Health and Human Services Health Resources and Service Administration National Sample Survey of Registered Nurses (NSSRN) showed that "among those nurses who reported leaving their jobs in 2017, high proportions of US nurses reported leaving owing to burnout" (Shah, et al., 2021, p. 6).

Evidence from our local critical care departments in Nova Scotia showed burnout rates in 2018 that were consistent with national results, as "high and moderate levels of emotional exhaustion were 27.3% and 39.4%, respectively. Depersonalization was high in 13.9% and moderate in 33.3%. Low personal accomplishment was experienced by 27.9%, with a further 37.0% experiencing moderate personal accomplishment. 55.2% of participants reported moral distress at least a few times a month and 29.9% reported it at least once a week" (Hancock, et al., 2018). In 2019, Nova Scotian intensivist – Dr. Jennifer Hancock – further compiled data on "Promoting Resiliency in ICU Healthcare Professionals at the QEII." Her survey results revealed that the experience of burnout in critical care providers in Halifax was prevalent, and the expression of its symptoms varied across each professional group working in ICU (e.g., respiratory therapy, nursing, physicians etc.) directing her focus towards developing solutions that were inclusive of the entire team (Hancock, Hall, & Flowerdew, 2019, p. 473).

In 2020, Dr. Hancock conducted focus groups to gain further insights from her ICU staff related to the daily minutia of stress in critical care. The caregivers reported both the benefits of working in the ICU (e.g., helpful colleagues and strong expertise) as well as the negative effects of ICU work (e.g., a lack of resources, disengaged management, poor team dynamics, and exposure to high-intensity situations) (see Figure 7) (Hancock, et al., 2020, p. 1543). Efforts to address burnout in Halifax's central ICUs are ongoing, and the results from both the 2019 survey and 2020 focus groups have been published to recount both the numerical findings of how many staff are burnt-out (i.e., quantitative ratings) alongside the results gained from participant narrative indicating the specific social and cultural contributors to burnout (i.e., qualitative themes).

Hancock, et al. (2020) found that three major factors contributed to burnout and moral distress. The three categories include organisational issues, exposure to high-intensity situations, and poor team dynamics (see Figure 7). These categories were then divided into additional subcategories to relay the specific problems faced by staff.

Figure 7: Themes Causing Burnout and Moral Distress in ICU (taken from Hancock, et al., 2020, p. 1543)



In terms of organisational issues, ICU staff often referred to a lack of adequate physical resources and safe staffing levels with which to do their jobs effectively. This problem became significantly worse after the Covid-19 pandemic as many nurses and physicians left their jobs, moved into different areas of practice, or retired altogether. In terms of being exposed to high-intensity situations staff listed how they provide futile care and end-of-life care often, which contributed to their feelings of grief, sadness, distress, and an overall lack of closure. Here are two quotes from ICU staff who speak to this, having participated in Hancock et al.'s study:

> "Got a call to palliative care to see a patient who was there with pancreatic cancer, metastatic, who was there for palliation but now was hypotensive and [the] palliative care physician wanted to know if I would take that patient to the ICU, put them on pressers because maybe they'll get another couple of months to live. So, you go down and then you spend an inordinate amount of time trying to talk to this lady and her family about why you're not going to do what you've been asked to do and it's emotionally exhausting" (Hancock, et al., 2019, p. 29).

> "...I was coming into this situation with this family in the middle of the night that I didn't know, I didn't get time to get to know and then all of the sudden like I would go do something and they're up like oh, why are you doing that?...they left the breathing tube in because they didn't - the wife didn't want to hear the sounds, and the breathing, and the struggle, and the secretions and didn't want to have to deal with that because that's what she had seen with her mother and she felt it was very distressing for her and she didn't want that case for her husband. And so, they left the breathing tube in, he wasn't on the ventilator. He was just T-pieced with humidified air for comfort, but in having the breathing tube still in you know, he's now comfort care, he's got a tube hanging out of his mouth so every time he would cough we would have to go in and suction him and that was more uncomfortable and more distressing for the family, and then you'd have to try and explain what was going on and it's kind of like did anyone actually say like this is what it means to do this and you know, we could have had the patient have the breathing tube out, have certain lines or whatever out and we could have moved them to a private palliative care bed..." (Hancock, et al., 2019, p. 31).

The team also reported experiencing the effects of poor communication, workplace violence, and bullying (Hancock, et al., 2020). Here is a sample of quotations where the team discusses the "general culture of shaming and bullying" in ICU:

> "It affects everybody, it affects relationships between the nurses, it affects relationships between the doctors, the doctors and the nurses. Even you know, like I said the supportive staff, the clerks, the aids, everything. It just takes one bad apple no matter where it goes for people to feel that tension, and that stress, and that pushback..."
>
> "...then you could go in the next day and have a completely different group of nurses and have the worst day ever."
>
> "...we were talking about nurses who are like the mean ones like there is one ... unit that I have severe panic attacks before I go in and so I switched my shifts, so I don't have to" (Hancock, et al., 2019, p. 38).

My own experience with workplace bullying ran the gamut, so to speak, including all sorts of incidences where people would swear at me, yell at me, demean me, or even push me physically out of their way. It was very stressful dealing with so many different personalities, and some of them you knew to watch out for, but even attempts at fawning were futile, it was often best to avoid hostility. [26]

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[26] Fawning is "a trauma response where a person behaves in a people-pleasing way to avoid conflict and establish a sense of safety. When faced with trauma, fawning serves as a coping mechanism. By developing a fawn trauma response, trauma survivors attempt to avoid conflict by pleasing their abuser" (Fenkel, 2023, para. 3-4).

> I picked up the phone, "OR!" I said quickly. "Hi, it's Ned, I have this patient who is coming for an echo-guided pericardiocentesis, and I wanted to ask if you could make sure we have a 16-18 gauge, Teflon-sheathed needle, 6 Fr to 8 Fr dilator and introducer sheath, J-tipped guidewire, pigtail angiocatheter… "One, second," I said, as I was writing furiously to capture the specifications. "Listen," he replied, "put me on with someone who knows what the fuck they are doing." I paused… "I can help you, I just needed to hear that last part *click*…" my words trailed off as I processed the sound of the receiver hanging up mid-sentence.

2.1.3 The State of Things

Since many national and international 'calls to action' to address burnout were released by medical communities (such as the CAM and AMA) between 2017 and 2019, as well as the Covid-19 pandemic being declared on March 11, 2020, caregiver shortages have gotten worse. In 2021, Statistics Canada estimated that "32,295 regulated nurse positions stand vacant, with nearly half (46.5%) of vacancies for RNs/RPNs staying open for 90 days or more" (CNFU, 2022, p. 5). It was also determined by the Canadian Federation of Nurses Unions (CNFU) that "Pre-pandemic, 60 percent of nurses said they would leave their jobs within the next year; more than a quarter of these nurses said they will leave the profession altogether;" whereas "A 2021 survey of nurses conducted by the Registered Nurses Association of Ontario revealed that 4.5 per cent of nurses in Ontario planned to retire now or immediately after the pandemic." A year later, "At least 13 percent of nurses aged 26-35 reported being 'very likely to leave the profession' once the pandemic dies down" (CNFU, 2022, p. 5).

Today, Duong and Vogel report in 2023 that "physicians from all over the country are past the point of exhaustion," according to the Canadian Medical Association's (CMA) President Alika Lafontaine. Lafontaine noted that "most of the 4121 physicians surveyed by the CMA in 2021 reported unhealthy working conditions, including heavy workloads (60%) and long hours (56%)" and that "nearly half (49%) said they were considering reducing their clinical hours by this year" (p. E309). As well, "a recent Statistics Canada survey on experiences of healthcare workers during the Covid-19 pandemic showed that about 9 in 10 nurses (92.0%) reported feeling more stressed at work than before the pandemic" (Duong & Vogel, 2023, p. E309). The problem is that "you're increasing the amount or volume of services that need to be delivered to make up for what was not provided over the past two years, and then you're adding on to that the overtime hours, which research shows results in burnout," says Lynn McNeely, manager of health workforce information at CIHI (Duong & Vogel, 2023, p. E309).

CIHI data further reports that "Overtime hours among health care workers have been linked to decreases in physical and mental health and well-being, which can have long-term implications for the health of the health workforce and for health service delivery" (Duong & Vogel, 2023, p. E309).

Further to this, “Increased stress was also reported by other health professionals including physicians (83.7%), personal support workers (PSWs) or health care aides (83.0%), and other health care workers (83.0%),” and Lafontaine (CMA’s president) also rightly said, “The most resilient parts of any health system are the providers who work in them,” which points to a major problem of diminished capacity and staying power due to burnout (Duong & Vogel, 2023, p. E309).

Again, it is important to note above how burnout is being used as a catch-all term to describe many of the problems associated with modern healthcare institutions and the struggles facing healthcare providers. In actuality, burnout is just *one* phenomenon operating within a milieu of other stress responses. The term burnout *alone* is not sufficient to describe all of the plights special to healthcare work.

2.2 The Effects of Stress on the Mind/Body

What is important for my focus here is that stress reactions – although they represent normal human responses – do indicate that an individual is trying to adjust to or process something, whether it be change, discomfort, new events, new ideas, or perceived threats. Adjusting to, or accepting a new routine can be stressful, although this type of stress reaction is normal and can be a positive motivator for growth and development. Conversely, the type of stress that stems from a perceived threat often causes a quick cascade of stressful feelings, adrenaline, and cortisol release, followed by mental and emotional confusion, tension, discomfort, and worry. Stressful experiences in healthcare are no different. Sometimes, the stressors in medical situations are straightforward and can be more similar to the feeling of stress you get before you give a public lecture, in that the feelings lay under the surface but are somewhat manageable; other times, the stressors in healthcare seem to resemble a real threat like facing a bear in the woods, they are loud, gory, in your face, or filled with unpleasant sounds or smells. You may even feel as though your life is in danger, even when it is not.

2.2.1 Emotional Strain & Coping Mechanisms

A cornerstone of anxiety is when individuals perceive a threat in a situation (past, present, or future) that may not be harmful at all, but that they presume will be too difficult to cope with. Take public speaking for example, no harm will truly come to the speaker, but their body still reacts as if it will by producing sweat, increasing blood flow to the extremities, dilating one’s pupils, and heightening one’s senses. Stress may also change the way someone normally thinks or acts, and as McEwan describes, since “the brain is the central organ of stress,” it can be changed by recurrent stress and overuse of particular neural pathways (2017, p. 1). “Stress can cause an imbalance of neural circuitry subserving cognition, decision making, anxiety and mood that can increase or decrease expression of those behaviours and behavioural states" (2017, p. 1). In critical care medicine, consistent exposure to chronic stress can literally change a person's brain. McEwen (2017) writes that:

> "The brain is a biological organ that changes in its architecture and its molecular profile and its neurochemistry under acute and chronic stress and directs many systems of the body—metabolic, cardiovascular and immune—that are involved in the short- and long-term consequences of being 'stressed out' and the consequent health-damaging behaviours. The neural circuits in a healthy brain are remodelled by experiences to enable behavioural responses that are appropriate to what the individual is experiencing, e.g., being more vigilant and anxious in a potentially dangerous environment. The healthy brain is resilient and neural circuitry adapts to a new situation along with underlying changes in gene expression. The unhealthy brain may not be so plastic, or it may have maladaptive circuitry or plasticity and, as a result, is less able to adapt appropriately or likely to 'get stuck.' In these cases, there need be external intervention involving pharmacological agents and behavioural modification" (p. 2-3).

People who have grown up in emotionally unsupportive environments, or environments that are filled with continuous stressful stimuli, may have altered their brain function and their basic way of navigating the world. Kascakova et al. (2020) who analysed responses from a representative sample of people in the Czech Republic write, "our results highlight the relevance of various types of childhood trauma as possible factors contributing to anxiety and pain symptoms in adulthood. Namely, emotional abuse and neglect and physical abuse were associated with anxiety and chronic pain in the clinical population" (p. 11). Further to this, Shaw (2003) found that "exposure to intense and chronic stressors during the developmental years has long-lasting neurobiological effects and puts one at increased risk for anxiety and mood disorders, aggressive dyscontrol problems, hypo-immune dysfunction, medical morbidity, structural changes in the CNS [central nervous system], and early death" (as cited in Schneiderman, Ironson, & Siegel, 2005, p. 609).

Understanding occupational stress does not only require a thorough investigation into the types of stressors or stressful phenomena that can take place within an organisation, but it also requires understanding the diverse community of individuals that will be operating within these spaces, those who very well may have already been exposed to a lifetime of trauma. Some of these individuals may have yet to acknowledge the degree of distress they have experienced to date in their personal lives, meaning they may have not sought professional or personal support for this, making it even harder to pinpoint the cause and/or reason for which certain individuals appear to either cope in medicine or not. The baseline expectation should not be that people are alike emotionally, nor that most people should respond to distressing medical situations in the same calm and unbothered manner. Just as people are neurodiverse, people are emotionally diverse, a factor that should be accounted for.

How people approach distressing events is variable. As previously stated, this can depend greatly on the type of stress, the degree of stress, as well as the duration someone is exposed to stressful stimuli. Similarly, "there are also individual differences in stress responses to the same situation"

(Schneiderman, Ironson, & Siegel, 2005, p. 607). In my experience, things that made me feel uncomfortable were sometimes unique to me alone, in other words, no one else seemed to find that circumstance stressful; and other times my distress was mutually shared with the whole team, where we all found a circumstance to be disturbing or stressful. One example of sharing distress is when a patient was admitted for surgery having been 95% burned (of their total body surface area). They crashed their motorcycle into another oncoming motorcycle, causing both bikes to go up in flames. The patient had lost extremities and was in such bad shape the entire team hoped they would pass on peacefully. Everyone found this case extremely sad and horrific to witness.

In other cases, I was the only one who seemed bothered; for instance, every time someone needed to have an amputation, I would feel a little weak in the knees. The first amputation I ever experienced was a patient having an "above-knee-amp" or AKA, where afterwards the patient attendant did not know what to do with the leg. They decided that instead of disposing of it or sending it to biomedicine, or even the laboratory, they left it sitting on the filing cabinet beside the OR desk. I looked over as the specimen was teetered at just the right angle to hang off the cabinet, which began dripping blood down the side of the drawers. I recall thinking that I did not want to have to pick it up or touch it. Something about feeling the weight of human body parts once they have been separated from the person was always eerie and unsettling.

Over the years I would receive implicit advice from colleagues on how to cope. Some of the recommendations were (1) to distance myself from the patient – since "it's easier if you don't get too close;" (2) not to dwell on negative things – to "just think of something happier;" and (3) to do nothing – in other words, find a way to ignore what just happened, pretend otherwise, or cope; all of which may include staying on task, moving on to the next patient, or using dark humour to deflect discomfort (even if this requires dehumanising colleagues or patients). The use of dark humour is common in medicine, and presumably other related professions (e.g., fire service or police), and it is part of the culture. I often recall reflecting on my use of *dark* or "gallows" humour. [27] I could feel the wrongness of it, but it also served me in a particularly beneficial way; it helped me to exist in a stressful space while still finding a way to laugh and relax around colleagues.

> I called over to the charge nurse to ask her a question, I said, "That plastics patient hasn't called back, right?" She looked over at me, and said wryly, "He's probably back in jail already, eh?" We both laughed. "No seriously," I said, as I asked again, "Should we find another way to reach them so they can get their surgery? Their phone seems disconnected." "You can ask the

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[27] Gallows humor, a term that "itself reveals its origin and meaning" by referencing the wooden apparatus that was once used to hang people and execute them, refers to humour that "arises in connection with a precarious or dangerous situation" (Obrdlik, 1942, p. 709) such as taking a horrific situation and still finding levity in it.

> broken jaw he probably punched in room twelve if he knows him?" She said smiling. I paused, then said "Right, fractured phalanx[28], I get it, *ha ha…*"

To be clear, there was no factual connection between the person who had a broken finger (i.e., phalanx) and the individual who was having their jaw wired in room twelve. However, a lot of the dark humour around plastics patients (plastic surgery is a speciality that deals with the reconstruction and moulding of a patient's body, tissues, muscles, and nerves after injury or for cosmetic purposes) centred around how they were often tough guys who frequented prison, and how they also got into a lot of fights, breaking fingers, and jaws in the process.

Other times, the language I used was simply straightforward and factual but would sound horrifically callous to outsiders.

> I rushed onto the unit, throwing my coat and bag on the chair beside my computer. I was arriving later than I wanted, so I quickly found the charge nurse to discuss the patients admitted to the unit. She was busy cleaning up a patient (since the assigned nurse was on break) but she nodded to acknowledge that she would come find me to let me know what was going on. I leafed through the patient census, marking off patients I had already come to know, and marking a "N" by new patients whom I had yet to visit and add to our database. "Is bed nine dead yet?" I asked the clerk, to which she replied, "No not yet, but it's happening soon." "Okay great," I said, "We're going to probably need space on the unit for the Sugarbaker[29] that's coming later."

The purpose behind this statement was not meant to degrade or demean the person in bed nine, instead, it was simply to garner whether I would have to visit the patient, record their final statistics and death, and discharge them from the ICU database before the new patient arrived. Obrdlik (1942) astutely writes that "The positive effect of gallows humour is manifested in the strengthening of morale. Its negative effect is revealed in its influence upon the disintegration of those toward whom it is directed" (p. 709). Dark humour is certainly a coping mechanism, and healthcare staff are well versed in reserving their dark humour for their colleagues.

Dark humour is mostly employed within private circles and cliques, although since it does happen in the spaces and hallways of public institutions it is sometimes within earshot of patients.

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[28] A phalanx is the digital bone of the finger.

[29] A Sugarbaker surgery is named after Paul Sugarbaker who developed the procedure at the Washington Cancer Institute. "It involves extensive open abdominal surgery to remove the affected tissues. This is called 'cytoreduction', which means 'reducing the number of cells' (cancer cells). At the end of the surgery, an infusion of heated chemotherapy helps to kill any stray cancer cells that may have been left behind" (Cleveland Clinic, 2022).

Laughter and humour do provide patients and providers with a certain degree of levity in an environment that is rife with stress and suffering, however, this practice also "dehumanizes patients, undermines trust in practitioners, erodes the character of health care as a sector, and fosters cynicism and detachment among trainees during crucial phases of their professional development" (Piemonte & Abreu, 2020, p. 608). Piemonte and Abreu argue that "Rather than simply accepting callous humour as a method for coping with tragedy, those of us in medicine and medical education should encourage our colleagues and learners to reflect on the moments in medicine that shape them, to confront vulnerability, and to acknowledge feelings of powerlessness in the face of death" (2020, p. 612).

Authors Souza, Silva, & Alves de Sousa Costa (2018) conducted a literature search in "Latin American and Caribbean Health Sciences Literature (LILACS) and Nursing Database (BDENF) via Virtual Health Library (VHL) and Scientific Electronic Library Online (SciELO)" to better understand "what strategies nursing professionals adopt to cope with occupational stress in hospital settings" (p. 494). Out of 25 selected articles, which were assessed and categorised using the Coping with Job Stress (CJS) scale ("which classifies ways to cope with problems in the workplace under three categories: control, escape and symptom management") identified "4 control, 8 escape and 7 symptom management strategies" (p. 493). These lists can be found in Appendix 3 and may be of interest to the reader. This list provides us with a selection of approaches that healthcare staff may automatically or unconsciously employ to help them cope with the stress of their workplace and overall, relieve suffering.

In the category of *control* strategies, Souza, Silva, & Alves de Sousa Costa explain how the desire to control motivates workers to "become aware of environmental demands, and proactively seek to modify stressful situations as a way of coping" (2018, p. 495). This includes problem-solving, formulating solutions, as well as seeking educational, emotional, social, or informational support from others. However, this approach may increase stress in healthcare, as the authors cite how in a study with 18 nurses working in onco-hematology, which is a unit "characterized by chronic patients under unstable clinical conditions" had consequential emotional repercussions which hindered nurses from proactively seeking to solve problems (2018, p. 495). Caregivers may also engage in controlling behaviour by reframing their situation in a positive way, where they look at the beneficial aspects of care delivery such as how organ donors are giving sick patients a second chance at life – this is what the authors refer to as positive reappraisal (2018, p. 495).

Importantly for this project, they also note how "dialogue affords relief to professionals," i.e., being able to talk about their problems or their emotions, which "reduces the tension caused by stress;" although, "in a study conducted with nursing professionals who provide care to potential organ donors in an intensive care unit (ICU), the institution — as most hospitals — did not provide any support, as there was not any specialised professional available for this purpose" (Souza, Silva, & Alves de Sousa Costa, 2018, p. 495). This problem is evidently not unique, given the high rates of burnout cited throughout this project, and little reference to ICU team members who found sufficient support in their unit. There is a deficit of support systems for emotional management across many global hospitals, specifically in critical care. In my experience, despite the presence of human resources, employee assistance programs, bioethicists, psychologists, psychiatrists, and social workers – whose time is often taken up helping patients –the task of supporting the emotional well-being of critical care providers is not designated to anyone directly. In places like the ICU where death and trauma are common, 24-hour psycho-social-ethical-spiritual support is likely a necessity.

Strategies to *escape* stress included avoidance, attenuation, or actively diminishing thoughts and feelings, focusing on the work specifically, and distancing oneself from situations or patients. The authors note that "with nursing professionals who provide care to potential organ donors in ICU, use of this strategy [e.g., distancing oneself] contributed to repress feelings and caused fatigue, stress and tiredness" (Souza, Silva, & Alves de Sousa Costa, 2018, p. 499). Staff also escaped stressful feelings "by involving themselves deeper in patient care tasks," they avoided "developing affective ties to patients and their relatives," and avoided bonding as "a mechanism of defence against stress, as it allows workers distance themselves from the situation patients and relatives undergo" which helped them attenuate "their own suffering" and "to distance themselves from imminent death" as "preparation to cope with it" (2018, p. 499). Caregivers also shifted stressful responsibilities onto senior staff (e.g., nursing supervisors) such as making difficult decisions, to better cope. Lastly, staff chose to avoid stress by leaving the workplace, quitting their profession, or changing hospitals (2018, p. 499).

Some positive *management* strategies that the authors found included participating in leisure activities, engaging in physical activity (to release endorphins), seeking support from religious or spiritual mentors, relaxing after a shift, and generally engaging in positive and uplifting activities both in daily life and within the workplace (Souza, Silva, & Alves de Sousa Costa, 2018, p. 500). However, presumably when any remedy is opted for as "the single strategy used to cope with suffering" this "might alienate the professionals and increase their suffering," which is why solutions to emotional distress should be dynamic, diverse, consistent, and easily accessible in the workplace. Their study also found that caregivers tried "to control their feelings and actions in the presence of stressors," which is a form of emotional and behavioural management (Souza, Silva, & Alves de Sousa Costa, 2018, p. 500). We will discuss the concepts of emotional management and emotional labour thoroughly in Chapter 5.

A strong part of the narrative and the many arguments made within this project all seek to impress upon the reader how "Employees working in the health care sector are often expected to express 'good' manners to the patients and their families despite their true feelings" (Loh, et al., 2018, p. 625). Loh and colleagues (2018) express how "in particular, they are required to invest their energy to deal with clients' negative moods or to handle difficult situations such as death and dying" (p. 625), activities that are distressing over time. Sutton and Norton (2022) studied the effects of emotional management in an adult ICU in England, where:

> "The results showed that some CCS [critical care staff] may consciously block out difficult emotions for sustained periods of time, which corroborates research showing intensive care staff's preference for avoidant methods of coping. However, there is ample evidence suggesting emotional avoidance is not sustainable and instead, it may contribute to burnout and exacerbate PTSD symptoms. Similarly, not giving time to process the psychological impact of difficult events because 'it's just part of the job' risks staff carrying a heavy emotional load" (Sutton & Norton, 2022, p. 657).

Beyond the coping strategies that healthcare workers devise on their own, there are also public messages used to target recovery from stress, such as those built around becoming more *resilient*. This narrative can be additionally damaging. If we consider how telling someone to "Take more baths," "Do yoga," or "Find ways to cope" after having witnessed horrific traumas, we might begin to see how this is a pale attempt at helping someone to truly feel better. When it is suggested either literally or passively to caregivers that (1) feeling better is easy, "just be more resilient," or (2) they simply are not trying the right things, "you need to be more positive," this may make them feel worse. The effects of these suggestions can be toxic because they imply a degree of personal blame or inadequacy. These passively distributed lifelines imply that help is out there if the people are willing to go find it, which can leave staff feeling lost or responsible for maintaining this type of occupational support on their own time, a task that requires *labour* on behalf of exhausted caregivers.

The depth in which medical professionals are taught to handle emotionally challenging situations in ICU is clearly inadequate, despite many efforts to address this dimension of caregiving (e.g., CanMEDS, resilience models, and peer-support) given the rates of burnout and high levels of attrition cited in previous chapters. Cho, Sagherian, & Steege, (2021) who sought to better describe "nursing staff perceptions of resources provided by hospitals during the Covid-19 pandemic in the United States" (p. 174), "found that almost half of the participants did not report receiving any additional support" (p. 180) and that "Critically, nursing staff are not reporting increased access to mental health resources, which is likely essential to maintaining long-term well-being and sustainability of the nursing workforce" (p. 180). Greenberg et al., (2021) looked at nine hospitals during the pandemic in the United Kingdom, where they "identified that, amongst the participants who were staff working in ICU during the current pandemic, many reported substantially raised levels of poor mental health and in particular high rates of probable PTSD. The increased risk was particularly evident amongst nursing staff" (p. 5).

The 'softer' or more nuanced support systems that are needed in ICU are easy to overlook amidst the shuffle of critically ill patients, overstimulation from medical tasks, and constant admissions and discharges. These nuanced supports would include the maintenance of psychological safety, high levels of peer support and peer mentorship, and well as access to well-immersed and easy-to-access mental health supports daily, which are inadequately maintained and often completely absent. Loh et al. (2018) who administered questionnaires to 311 nurses and 113 nursing assistants working in Malaysia asking about the psychological safety climate (PSC) and emotional demands in the workplace, reported that PSC "as an organizational resource is a stronger moderator of emotional demands to psychological health relationship than job task resources" and that their "findings suggest that PSC should be the main target in designing interventions to prevent the detrimental effects of occupational hazards such as emotional demands for health care workers, specifically to reduce somatic symptoms" (p. 639).

2.2.2 Occupational Stress Defined

Now that we have had a deeper look at the somatic ways stress can affect caregivers, let us back up a little bit and consider the broader picture of how occupational stress operates. As a reminder, stress is "any physical or mental pressure, or cumulated pressure, caused by stressors which destabilise individuals" (Souza, Silva, & Alves de Sousa Costa, 2018, p. 493) which can arise in response to "any characteristics of the job environment which pose a threat to the individual" (Beehr & Newman, 1978, p. 668). Thus, job stress, or occupational stress requires a new definition since this type of stress is special to the interaction between a person and their job. Beehr & Newman rely on the following definition of job stress (what we are referring to as occupational stress in this project): "Job stress refers to a situation wherein job-related factors interact with a worker to change (i.e., disrupt or enhance) his or her psychological and/or physiological condition such that the person (i.e., mind-body) is forced to deviate from normal functioning" (1978, p. 669-670).

Specifically, "two types of job stress may threaten the person: either demands which [they] may not be able to meet or insufficient supplies to meet [their] needs" (Beehr & Newman, 1978, p. 668). Certain occupational settings expect professionals to deal with high levels of unavoidable stress. Consider the occupation of pilots, firefighters, or even gladiators in ancient Rome (yes, this was considered a profession) – these jobs all expect individuals engaged in this type of work to assume a high level of risk, whether that be risking a plane crash; fire exposure or lethal burns to the body; or death and dismemberment. Ways to avoid these types of harmful events are often 'baked into' the job itself (e.g., the use of safety equipment, safety protocols, and education) however because the likelihood of these events occurring can be high in these types of occupations, there is also the constant awareness of the likelihood of these risky events taking place, which can cause significant anticipatory stress for workers in these fields.

In the examples I gave above, the intensity of crashing a plane, being burned, or having your arm cut off is always high, for this, there is no question. This can be likened in healthcare to when the patient dies or the patient suffers an accidental anoxic brain injury, the feelings associated with severe events are often very 'bad'. In addition to actual stressful events, there is also anticipatory stress related to one's perceived understanding of the threat itself – i.e., knowledge of its possibility – and how capable one is of handling the associated levels of stress that coincide with this degree of consistent uncertainty. The impact of both situational stress and anticipatory stress will also relate to the duration of exposure to such events, i.e., how frequent they are. All these factors, and many more nuances will contribute to whether an individual is capable of (or willing to consent to) handling such high stress daily. Consider the following example: my father was a pilot with the Canadian Air Force in the 70's, and I recall him telling us many stressful stories. In one case, he said:

> "I hit a swarm of locusts on my approach to the runway and had to abort the landing. I then declared an emergency to the tower who then gave me 'bail-out' vectors so that the aircraft would crash in an unpopulated area. Due to my leg length, I had been told that in an ejection I would probably lose my legs as they would not clear the dash. So, it was land blind or not at all." According to him, "The swarm of locusts had created a layer of green slime across the windshield," which in case you didn't know, doesn't have any windshield wipers, "This made it impossible to see out of the cockpit." He recounts how "I realised I could look out of the side of the plane's window while turning the jet on its side to know how far away the ground was. I did this multiple times attempting to land safely. I could see the sweat beading on my leather gloves and dripping down my arm, that's how stressed I was! Finally, I made it to the ground. I think this is when I considered going back into engineering school…that could have been my last time flying or doing anything really."

My father is a stoic and confident man who does not succumb easily to fear or stress. He was brought up in rural Cape Breton in a mining town and was one of five boys in a military family, he trained in multiple martial arts styles of self-defence (obtaining various black belts), and after being a pilot he would routinely walk under the Halifax bridge without a safety harness to inspect its structure as the lead engineer. Despite his bravery and his tolerance for higher risk-taking, the type of high-reward-high-cost lifestyle that came with being a pilot was not viewed by him as sustainable. It was an experience he was willing to risk doing for a short period, but not one he felt he could manage in the long run. Even though he enjoyed flying jets, being a pilot was a profession that simply came with too much stress and uncertainty. This is a good example of how the job itself can be a source of stress simply by virtue of the type of work that is being done, but that this is only a partial aspect of workplace stress. Personal characteristics and self-knowledge of one's preferences are also part of gauging and managing stress levels.

Critical care medicine is unique in that it combines environmental factors (i.e., exposure to chaos, death and dying in hospitals) *with* human or personal factors (e.g., levels of tolerance for risk or a stomach for 'blood and guts'), and organisational factors (administrative engagement and/or institutional practices), all of which can conspire to cause individual or collective stress. The variables associated with occupational stress are many, and there are competing lists in the literature; however, Appendix 4 from Beehr & Newman does a good job of showing the plethora of possible contributors to job stress and their table is quite comprehensive. The authors write that their table "represents a conceptualization of the major facets (dimensions) of the job stress-employee health research domain." They explain that "This facet design is the result of an inductive-intuitive-inventive process and includes factors the authors think ought to be studied in order to understand the phenomena within this research domain" (1978, p. 670-674).

The facets listed in Appendix 4, all of which are associated with job stress, were published in 1978 in their article *Job Stress, Employee Health, and Organisational Effectiveness*, which is now forty-five years old, however, despite how many years have passed since it was conceptualised, many of these facets are still relevant today. Their relevance will indeed depend on the context (i.e., different job environments) and the uniqueness of individual employees, but ultimately, despite the modernisation of the workplace (e.g., via the use of iMacs, standing desks, equity-diversity-inclusion-accessibility (EDIA) principles, and workplace violence policies, etc.) the personal, environmental, and process factors that can affect a person's level of stress still operate in today's context. In this section, I would like to do a quick literature review of occupational stress and burnout.

There is little agreement on exactly when occupational stress became a definitive concern for employees/employers. Joseph Melling writes that workplace stress "was not recognized by a significant section of the professional scientific and medical world until the 1940s" (2015, p. 161). Whereas Schaufeli, Leiter, & Maslach write that "an overarching development...that seems to have fostered burnout is the rapid and profound transformation from an industrial society into a service economy that took place in the last quarter of the past century" (2008, p. 208). Joseph Mellon cites that "stress remained, in theory, and experience, a relatively marginal phenomenon until a particular conjuncture of societal and cultural shifts in the expectations of populations in affluent countries from the 1960's" (2015, p. 174). Further to these citations, the earliest use of the term *occupational* stress is found in McLean (1974) where he considers an occupational "stress" or "stressor" to be any work-related factor which produces a maladaptive response (referring to both the adverse effects had on work performance and interpersonal relationships).

Graham Greene, an English writer, and journalist published *A Burnout Case* in 1960 which tells the story of an architect named Querry who abandons his career and life to seek solitude in the Congo to escape his disillusionment with his purpose, and his anxiety as he has "lost the ability to connect with emotion or spirituality" (Davis, 1961). He begins working in "a remote African leprosery run by nuns and priests" where he gradually recovers (Davis, 1961). He is considered a "burn-out case," which was originally a term used to describe a stage of leprosy, which included "advanced nerve injury with loss of sensation or limb loss" (Franco-Paredes & Tuells, 2023, p. 86). This usage is thought to be the origin of the term burnout as it was first applied to a professional with "psychological depletion," as Franco-Paredes and Tuells put it, they write on how the comparison of Querry's mental state of "emotional numbness" is not unlike the burnt-out case of leprosy (2023, p. 87).

Herbert Freudenberger was the first to coin the term "burnout" when referring to exhaustion in the workplace in his 1975 publication *The Staff Burnout Syndrome in Alternative Institutions*.

> "When burnout began to be described and discussed in the 1970s, it was primarily in reference to work in the human services, such as health care, social work, psychotherapy, legal services, and police work. Qualitative interviews and case studies gave a vivid picture of the experience in which people lost both their energy and their sense of the value of their job. The loss of meaning was especially poignant within professions dedicated to lofty goals to help and serve others. Tellingly, burnout discussions began within the human services because they were better able to give "voice" to issues of *emotions, values, and relationships with people* – concepts that had not been widely recognized within the research literature on the workplace" (Schaufeli, Leiter, & Maslach, 2008, p. 206 – my emphasis).

The use of the term *burnout* is relatively synonymous with occupational stress, although its particular use by health professionals early on (like Freudenberger) did connect this term uniquely to what can be considered the 'helping professions' like medicine. Freudenberger describes how he considered the word an "apt one" to portray how people felt, i.e., worn out, exhausted, and feeling the pressure of excessive demands placed upon them (Freudenberger, 1975, p. 73). Recall from earlier that burnout is specifically thought to encompass high levels of exhaustion and cynicism, and low levels of personal accomplishment (Maslach, et al., 2001). Other terms may describe occupational stress just as well, such as workplace expenditure or workplace fatigue, and even workplace disillusionment, but burnout is simple and intuitive and has become somewhat of a catch-all. Melling describes how:

> "The language of workplace stress was developed and adapted to meet the needs of those facing contemporary capitalism whose spaces and boundaries were shifting. In this deep transition, the vocabulary of stress gained currency to become a global means of exchange between actors who possessed distinct and conflicting concerns about work and who gave the term 'stress' different inflections to suit their needs and purposes" (2015, p. 164).

Early on, not only were workers attempting to put new words to their stress, or seeking to articulate the language around their sense of "mental disquiet," as Melling puts it, research experts were interested in studying the relationship between work and wellness within a new paradigm of labour delivery (such as the invention and nature of the "assembly line" for workers employed with Ford Motors)[30] where mental health professionals would need to ascertain new ways to approach the diagnosis of mental illness related to stress in the workplace while simultaneously reducing stigma (2015, p. 164-165). It is also important to note that the motivation behind understanding occupational stress is not always altruistic or for the benefit of the workers themselves, as often "research into effort at work was guided by an overriding concern with efficiency and economy. Projects conducted by industrial psychologists into the education, abilities and selection of labour were primarily concerned with aptitude and incentives" (Melling, 2015, p. 175).

Occupational stress can be viewed from the perspective of the employer, the researcher, the medical specialist, the psychiatrist, and the individual themselves – all of whom will have opinions that can help to shed light on the different operational aspects of the phenomenon. Take, for example, Dr. Freudenberger, a psychiatrist working in a free clinic in the 1970s working to help chronic drug users and other marginalised members of society recover from addiction. Freudenberger claims to have suffered burnout twice as a psychiatrist, giving him personal insight into this experience, which also allowed him to develop qualitative descriptions of what burnout is said to be like on the frontlines. In his 1975 publication, he says "We all know the story of the ulcerated executive and what he has done to himself" (p. 73). The psychosomatic symptoms of burnout for him included "a feeling of exhaustion and fatigue; being unable to shake a cold, feeling physically run down; suffering from frequent headaches and gastrointestinal disturbances" which he said, "may be accompanied by a loss of weight, sleeplessness, depression, and shortness of breath" (Freudenberger, 1975, p. 74).

He goes on to describe how virtually anyone can suffer burnout, depending upon specific personalities and situations, each thought to be associated with being burned out in the workplace. He refers to personality types like "the dedicated and committed worker" or the "authoritarian," he also points to roles as more or less important, such as "burnout of the *professional*" (1975, p. 74-77). He does little work to define burnout in healthcare, as he simply uses a dictionary quote that defines burnout as a verb "to fail, wear out, or become exhausted by making excessive demands on energy, strength, or resources" (1975, p. 73). The term itself is quite old, but its use in healthcare was new at the time. For Freudenberger, the term burnout could do a lot of proverbial heavy lifting, since it was quick and easy and could cover a lot of ground, including everyone from "the addict who shoots up

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[30] Ford Motors offered "a new way of manufacturing a large number of vehicles. This method of production was the moving assembly line. The most common feature of this assembly line was the conveyor belt. The belts were in use within other industries, including slaughterhouses. Moving the product to the worker seemed like a better use of time and resources. The Ford Motor Company team decided to try to implement the moving assembly line in the automobile manufacturing process. After much trial and error, in 1913 Henry Ford and his employees successfully began using this innovation at our Highland Park assembly plant" (Ford, 2020).

until he burns out and possibly dies" all the way to "the golf freak" who cannot stand to be away from the game (Freudenberger, 1975, p. 73).

Yet, compared to the golf freak, Freudenberger hints to his reader that there is something different about working in *caregiving* roles – such as the psychological therapy he provided in the free clinic. He describes how healthcare providers are "fighting a battle on at least three fronts" (p. 73) in terms of trying to please society, and patients, and to fulfil their own needs. Today, I would argue that this triad has become a five-pronged model, whereby providers must seek to fulfil the demands of society through political agendas, adhere to the protocols and expectations of their institution, cooperate with colleagues, and exist within specific subcultures, successfully treat patients (who are more comorbid than ever), while also keeping their sights on their own values and needs. [31] Freudenberger's insight into the unique struggle of healthcare providers would not stand alone for long, but it was indeed an early instance of wondering why caregivers seem to lose themselves in their dedicated efforts to help patients.

Maslach, the woman now behind the most successful tool designed to measure burnout (i.e., the Maslach Burnout Inventory or MBI), said in a live talk for DevOps Enterprise Summit in Las Vegas "If anybody ever says 'I invented the word burnout' for this stress response, it's not true. Nobody invented it. It's been around for a long, long time. It emerged as the language of the people" (Maslach, 2018). Maslach, Schaufeli & Leiter write that "the use of the term burnout for this phenomenon began to appear with some regularity in the 1970's in the United States, especially among people working in human services" (2001, p. 398). Maslach herself describes hearing the word burnout frequently from her father, a NASA engineer, who would say "Rocket boosters burn out, or ball bearings burn out" due to operating in such an abrasive environment (Maslach, 2018). Maslach, like Freudenberger and others before her, found this word to be a fitting one.

Maslach grew to have a deep interest in measuring what she thought to be burnout in healthcare contexts more closely, which eventually led to a more extensive understanding of the phenomenon. She wanted to know the "relationship people have with their work, and the difficulties that can arise when that relationship goes awry" (Maslach, Schaufeli & Leiter, 2001, p. 398). In 1976, while working as a social psychologist studying the effects of emotion in the workplace, she spent copious amounts of time rigorously interviewing individuals working in various helping professions (e.g., police officers or nurses) asking them about the stress of their jobs (Maslach, et al., 2001, p. 399). In her observations, she felt that *context* seemed to have extreme importance for how people cope with

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[31] Downer and Sinha explain how co-morbidity or multimorbidity, is "defined as having two or more chronic health conditions, is highly prevalent in Canada and is becoming a growing health concern as its population ages.(1) As an individual's chronic conditions tend to accumulate with age, so does multimorbidity and it is associated with an increased risk of short- and long-term mortality,(2) reduced function,(3) lower health-related quality of life,(4) and several other negative health outcomes" (2022, p. 404).

what happens in the workplace. Burnout appeared not only to be a stress response generated from working too much, instead, employees suffered emotional responses when provoked by stimuli in the environments they occupied (Maslach, 2001). Such provocations could shape one's "professional identity" through what might be called "relational transactions" with others (Maslach, et al., 2001, p. 400).

Maslach's lifetime interest in burnout was also sparked by an early experience with psychology professor Philip Zimbardo who conducted the famous 1971 Stanford Prison Experiment.[32] Maslach had just finished her doctorate and was working as an assistant professor at Berkeley University when she arrived to witness the unfolding of the prison experiment on day five of its execution. Apparently, after being quite upset by what she saw happening between the students (or research subjects) she advised Zimbardo to stop the project immediately, which he agreed to do (Ratnesar, 2011; O'Toole, 1997). After this experience, Maslach's work (like Zimbardo's) became heavily focused on dehumanisation.[33] Later in life, Maslach further observed prison guards (real ones this time) and emergency care providers following the cessation of the Stanford study, where she saw that despite being in *stewardship* roles so-called 'caretakers' risked growing to view their clients in an object-like manner, leading them to treat said clients in "insensitive, uncaring, and brutal" ways (O'Toole, 1997).

2.2.3 Measuring Stress in Medicine

Here we will look at an abbreviated overview of measuring burnout and examining workplace stress. Our interest here is chronically experienced stress, and what this does to workers who are immersed in stressful environments constantly, such as the ICU. If we want to know how much stress is taking place, researchers must know how to assess chronic stress, like burnout, and determine how it can be measured and explored. Assessing occupational stress can include both qualitative and quantitative measures. I have mentioned many tools and 'scores' throughout previous chapters, as a reminder e.g., Oldenburg Burnout Inventory/OBI, Single-Item Burnout Measure, the Copenhagen Burnout Inventory/CBI, Stanford Professional Fulfilment Index/PFI, Wellbeing Index, or the Healthcare Satisfaction Survey. Measurements like these are necessary to some extent because many

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[32] The Stanford Prison Experiment was designed as a "two-week investigation into the psychology of prison life [which] had to be ended after only six days because of what the situation was doing to the college students who participated. In only a few days…guards became sadistic, and [the] prisoners became depressed and showed signs of extreme stress" (Zimbardo, 2022). More information about this study can be found on their website at: https://www.prisonexp.org/

[33] Dehumanisation, according to the Merriam-Webster Dictionary is: to deprive (someone or something) of human qualities, personality, or dignity: such as (a) to subject (someone, such as a prisoner) to inhuman or degrading conditions or treatment, e.g., "… you treat people with respect, you get respect back. You treat them like animals, you strip search them, you dehumanize them, you lock them up, you don't feed them, etc.; or (b) to address or portray (someone) in a way that obscures or demeans that person's humanity or individuality (2024).

efforts to address burnout (e.g., programs, recovery strategies, etc.) have been viewed as important because the data indicates significant levels of stress.

Some of the leading scholars on burnout, Maslach, Schaufeli and Leiter, have done a good job of outlining it's "distinct phases of development" (Maslach, et al., 2001, p. 399). The first phase is described as the *Pioneering Phase* (Maslach, et al., 2001, p. 399). This initial stage of understanding burnout was born out of a grass-roots approach (like Freudenberger's) that catered to using qualitative reports to portray a worker's actual experience. This approach allowed researchers to gather thick descriptions from professionals about the stress involved in their daily work. This led to a general "conceptualization of job burnout as a psychological syndrome in response to chronic interpersonal stressors on the job" (Maslach, et al., 2001, p. 399). Freudenberger's work falls into this category, as he paints a detailed picture of why individuals work so hard. He writes:

> "We are there, first of all, to be of help, but also because we are struggling with our personal value systems…whatever it is we are seeking to do, we believe ourselves to be dedicated through our work involvement…we would literally rather put up than shut up" (1975, p. 74).

This passage speaks to Freudenberger's character and his professional identity. Freudenberger wanted people to know that caregivers do not just work hard because they must, they *feel* that they must, but also, they *want* to, because they believe in and are driven by a specific cause (e.g., helping patients recover, reducing their pain, preventing their death, etc.). Maslach's early work of rigorously interviewing caregivers also contributed to the pioneering phase, and together, their discoveries showed that burnout, and the signs of occupational stress, had both clinical (i.e., symptoms) and social-psychological (or relational) aspects. They further proved that the experience of burnout was indeed common to what they refer to as the helping professions, e.g., firefighters, police officers, medical professionals, psychologists, pharmacists etc. (Maslach, et al., 2001, p. 400).

The second phase of inquiry is referred to as the *Empirical Phase*. Early attempts to describe burnout were criticized for lacking empirical rigour and were charged as being more in line with "pop psychology" (Maslach, et al., 2001, p. 398). Burnout was seemingly something that anyone could experience, which led researchers to believe that the concept of burnout may not be unique at all. Maslach, et al. write that they may just be putting "old wine in new bottles" (2012, p. 296) as if to say they are simply over-describing exhaustion. The experience of burnout is also highly correlated with and like other well-established mental health issues such as depression and anxiety. Therefore, to distinguish burnout from other well-known experiences this syndrome needed to first be defined, and it also needed to be measured.

Thus, burnout research took a quantitative turn. It was proposed that questionnaires and surveys could be used to study larger populations of individuals. The most popular, and argued to be the most effective tool, has been the Maslach Burnout Inventory (MBI) released in 1981 by Christina Maslach and Susan Jackson. Today it is still considered to be the gold standard when it comes to analysing burnout. The first iteration of the MBI was directed solely at those working in helping professions such as medicine or law enforcement - i.e., the Health Services Survey (MBI-HSS) - however, due to widespread evidence of burnout within other professions they adapted the MBI-HSS to become the MBI-ES (for educators) and the MBI-GS (for general use). The MBI is used more widely than any other measurement tool for assessing levels of burnout, however, it is seldom used in isolation. Other measurement indices and surveys are often used in combination with the MBI to measure factors such as depression, work-life balance, and even civility (Maslach, et al. n.d.).

Maslach's research and her extensive measurement of the phenomenon allowed her and her colleagues to propose a multi-dimensional theory of burnout syndrome that consists of three core components: (1) *emotional exhaustion* (EE), (2) *depersonalization* (DP), and (3) *reduced personal accomplishment* (PA), all of which are assessed using the MBI tool. Emotional exhaustion captures how people begin to feel overextended in their roles and depleted of needed resources, both internal and external (Maslach & Leiter, 2008, p. 498). Emotional exhaustion is the component of burnout that can make one feel as though they need to detach and distance themselves from their job in order to cope, which is a natural reaction to being overextended. Maslach et al. write that emotional exhaustion is the "central quality of burnout and the most obvious manifestation of this complex syndrome" (2001, p. 402).

> I arrived home, two hours later than I had promised. My partner had eaten without me and was now walking our dog down the street. I felt drained, I had a headache, and I couldn't imagine cooking dinner for myself, so I grabbed a few chocolate-covered almonds to snack on. I sat on the couch, turning on the television to find a relaxing show – '*Friends*' was usually my go-to. It droned on in the background as I stared forward, trying to process the day's activities. I felt as though I had nothing else to give. I did not want to talk to anyone. I could not bear the idea of having any more responsibilities. Even the thought of standing up felt agonising. I simply wanted to stop existing for a few hours. But I could feel the mounting pressure of the tasks I knew were still undone around the house, which weighed on my mind. I knew if I ignored them, it would mean my partner would have to do them. I now felt guilty and somewhat angry. I could also taste the stress of the next day's work. I considered how I could just call in sick. Irritated, I turned the television off and went to bed.

Some authors have argued that exhaustion is so prevalent when defining burnout that the syndrome should be considered a one-dimensional phenomenon (Shirom, 1989). However, Maslach, Schaufeli and Leiter argue that exhaustion may be a necessary criterion for BOS, but that does not mean it is sufficient (2001, p. 403). Depersonalisation (or cynicism) follows with exhaustion, and it encompasses the negative disposition or callousness that can arise in the workplace, whereby individuals may distance themselves from others, or adopt a detached stance. Depersonalisation can make a person feel as though they are outside of themselves, having lost all sense of their personality or individuality. Reduced personal accomplishment is the last dimension of burnout, which is a self-assessment, where one feels that they are no longer contributing meaningfully to their job, accompanied by feelings of incompetence or failure (Maslach & Leiter, 2008, p. 498). This triad (EE, DP and PA) is the general framework that is considered to constitute burnout syndrome (BOS).

Factors that contribute to burnout include "excessive workloads, inefficient work processes, clerical burdens, work-home conflicts, lack of input or control for physicians with respect to issues affecting their work lives, organisational support structures and leadership culture" (West, Dyrbye, & Shanafelt, 2018, p.). In addition to the professional distress felt by healthcare providers throughout their careers, burnout may also be an "inevitable consequence of the way that medical education is organised and the subsequent maladaptive behaviours that are reinforced in healthcare organisations via the hidden curriculum" (Montgomery, 2014, p. 50). The traditional culture of medicine erodes providers, and age-old practices that attempt to condition students to become hardened to feeling or expressing emotion is compounded by the simple fact that medical life is inherently difficult. Senior staff can make residency training no easy task. Dr. Philip Stahel writes in his book Blood, Sweat & Tears "There was a joke that made the rounds about how interns took the blame for anything…attending surgeons would ask the junior house staff ironically: 'Why did you assassinate JFK?' then interns would reply something like, 'I don't know sir, I'm really sorry!'" (2016, p. 8).

Burnout syndrome (BOS) remains a complex interaction between the self and the workplace, and there are *personal* and *occupational* contributors. Initially, researchers were not sure if burnout was just a personal problem, or if it was one that organisations must address. It turns out, the answer is that these two factors are intimately enmeshed. Research evidence points to the fact that BOS is a problem for both individuals and administrators alike, as there exist the larger social, cultural, and economic forces that help to generate burnout symptoms as well as the unique and defining characteristics of individual persons can also promote or hinder their health and wellbeing. Therefore, we must simultaneously account for both the *structural* components of burnout, as well as the *interpersonal* effects of burnout (as this syndrome is also thought to be "the result of difficult relations with others at work") (Salminen, et al., 2017, p. 1).

In terms of structural components, the job itself can contribute largely to burnout, in terms of employees being overloaded, overextended, working too many hours, and with too many clients. Individuals may lack clarity on their role, they may lack the necessary resources, and they may not have a good relationship with their managers or coworkers (Maslach, et al, 2001, p. 407). Working within a helping profession can bring with it further exposure to intense interactions with highly charged emotions, and a constant requirement to give of oneself, all of which can be considered occupational hazards (Souza, Silva, & Alves de Sousa Costa, 2018). On the side, concerning the individual – or the interpersonal effects of stress – researchers have had to ask what is unique about providers who more easily succumb to burnout. What are the effects of age, experience, sex, gender, marital status, and education on BOS? Are specific characteristics or coping styles prone to the development of burnout, such as neuroticism, perfectionism, a need to control or please others, as well as lower self-esteem, or a passive and defensive nature?

To address the diverse nature of individual employees and the various types of careers available to them, Maslach, Leiter and Jackson proposed: (1) using a model of "job-person fit;" and (2) reconceptualizing burnout in its positive form to be understood as "work engagement" (Maslach, et al., 2012, p. 297). Job-person fit refers to the fact that there could be "mismatches" between a person and their work environment. Their model describes six areas of "work-life" that may not align, which can contribute to burnout: work overload, lack of control, insufficient reward, breakdown of community, absence of fairness, and value conflict (Maslach et al., 2012, p. 297). A mismatch in job-person fit can occur when there is a conflict between personal and organisational values, such as an employee who perceives there to be a lack of fairness in the workplace (Maslach, et al., 2001, p. 415). The complex interaction between these six areas and specific individuals will reflect important differences between how people perceive their work and how they will operate in different roles. This fact may suggest that human resource departments should screen employees before hiring them to determine the best possible fit.

Maslach, Schaufeli and Leiter also sought to reconceptualize BOS in the positive sense: as the opposite of 'work engagement'. They thought, what is the opposite of exhaustion, depersonalization, and lack of personal accomplishment? The authors suggest that work engagement is the antithesis of burnout, consisting of energy, involvement, and efficacy (Maslach, et al., 2001, p. 416). "Engagement is assessed by the opposite pattern of scores on the three MBI scales: unfavourable scores are indicative of burnout, whereas favourable scores are indicative of engagement" (Schaufeli, et al., 2008, p. 215). The trick is to determine what effectively engages people in their work in a meaningful way. Thus, burnout syndrome and work engagement are highly complex phenomena with a lot of moving parts, making it extremely difficult to pinpoint solutions.

Overall, Maslach, Schaufeli and Leiter argue that burnout is specifically related to five common elements: i.e., exhaustion is prevalent; there is an emphasis upon mental symptoms over physical ones; burnout is work-related; symptoms can manifest in previously healthy individuals; and lastly, decreased effectiveness occurs (Maslach, et al., 2001, p. 404). There is no question that Maslach, Jackson, Leiter, and Schaufeli have made substantial discoveries in the field of burnout research and have attempted to remedy inconsistencies in our understanding of burnout while also addressing the complex questions that have arisen over the years. They have succeeded in refining the definition of burnout and providing a framework with which to measure it (a tool that can be used across many occupations) and lastly, they have uncovered new and important questions about burnout that should be addressed by future research.

According to the authors, what is important for future research efforts is that: we should seek to better predict burnout before it occurs; we need to avoid an ivory tower approach and continue qualitative efforts on the ground; we need to better understand who suffers from burnout and why (personality type, age, gender etc.); better partnerships must be forged between researchers and practitioners; we should look to people "who are experimenting with various kinds of solutions" (Maslach & Leiter, 2015, p. iv) (Maslach says that whether these attempts have worked or not she wants to know the rationale behind their efforts); and lastly, that more formal empirical research on burnout is still required, however, we should not lose sight of the fact that we also need thick descriptions of the lived-experience of burnout.

Stefan De Hert writes that "there is an agreement that burnout in medicine is harmful to the professional, the institution, and the patient" (2020, p. 180), meaning there should also be no disagreement that solutions are needed. Various research efforts have been dedicated globally to understanding burnout syndrome, moral distress, and other occupational stressors that arise in medical settings; although, the key to "well-being may depend on different variables and therefore studies specifically focusing on different subpopulations are [still] needed" (De Hert, 2020, p. 180). In other words, local research efforts are useful in uncovering the different ways that burnout can present.

The predominant modes set forth to address burnout internationally appear to have traditionally rested on describing it, measuring it, and sharing those findings. Interventions for burnout are discussed far less often than are its causes and effects. I consider how *more* measuring is not necessary, instead, it is time to start trialling solutions and developing organisational plans to counteract occupational stress. In my opinion, interventions are indeed the next logical step, as we do have sufficient evidence that BOS is a major problem. The next step is to determine what is working (or not working) in hospital units to address recovery from burnout, as well as how to effectively prevent it. This can be effectively undertaken at the local level.

In this chapter, we have reviewed various terms that are used to describe stress (e.g., burnout, moral distress), disorders and syndromes that are provoked by or manifested by stress (e.g., anxiety, PTSD), terms that describe the causes of stress, e.g., trauma or moral injury, and lastly, terms that describe the symptoms of stress, e.g., dissociation, headache, or fatigue. We have also discussed the 'the problem', or the reason why stress in medicine is common and problematic for staff, as well as having outlined the ways in which stress can literally change a person's brain. I have outlined the types of occupational hazards or contributors to stress (generally), and I have demonstrated how researchers have tried to measure, define, and label occupational stress phenomena such as burnout. In the next chapter, we are going to look at ‘awareness’, a term that is used to describe a person or group's knowledge of, and/or their ability to perceive situations or facts. Awareness is an important skill needed to pick up on individual, social, and environmental cues – cues that signal when stress is present and how it affects a person, group, or unit. We will also assess the structure of the ICU environment and the aspects of this workplace that are stressful to bring awareness to the factors that contribute to occupational stress. We will also consider whether focusing our attention on the hidden or silenced aspects of care delivery that contribute to chronic stress may help us to target these problematic areas and bring greater awareness to them.

Chapter Three

Awareness

To expose and face the hidden aspects of a culture – aspects that are harmful to the members of that culture – *awareness* must be cultivated in the consciousness of these individuals so that they can see how certain activities and social pressures within their culture operate to subvert the foundations of their very wellbeing. The founding fathers of 'grounded theory' – Barney Glaser and Anselm Strauss – open Chapter One of their book *Awareness of Dying* with the following statement: "American perspectives on death seem strangely paradoxical" (1965, p. 3). What they mean by this is that Americans in the 1960's seemed to be quite "capable of accepting death as an everyday affair," mostly when discussing death in public forums such debates about euthanasia, talk of the "gruesome details" of an accident, or remarks on public obituaries; whereas, in contradiction to their comfort with these discussions, Americans also seemed "prone to avoid telling a dying person that he is dying" (Glaser & Strass, 1965, p. 3). Understanding this general paradox, i.e., between confronting death as a general fact of life, and directly confronting a dying person with their own mortality, is the entire point of their work on what they refer to as "awareness states" of persons.

Glaser and Strauss determined that because there existed various levels of social discomfort around death and dying in hospitals, elaborate and often subconscious mechanisms were used by healthcare staff and families to avoid having direct conversations with patients. They achieved this by engaging in a hidden process of tightly controlling the disclosure of information. The general sentiment was that if a patient did not know they were dying, they could not be upset by it. Meaning, the luxury of being "aware" (i.e., of the impending death of a patient) was reserved for the healthcare team and would only be disclosed to the patient by accident or if they felt it would be beneficial for them to know. In other words, the degree of information disclosed was used primarily as a mechanism to control the patient's emotions and actions. In this way, caregivers could prevent a patient from feeling immediate existential dread, yet these patients were also unable to fully confront their mortality/death since staff and family tended to avoid them, pacify them, or even lie to them.

This kind of tension, that Glaser and Strauss describe extensively in their book, relates well to what I am exploring in this project. Similarly, what they felt was strange about confronting death in American society in the sixties, I feel is strange in contemporary medicine around confronting emotions and naming trauma. Healthcare providers will freely talk about emotion in the abstract (e.g., how difficult a case was, or how sad it was that a family lost their daughter) but it is less common to witness emotional displays by healthcare staff, a fact that feels to me "strangely paradoxical" (Glaser & Strauss, 1965, p. 3). In my view, if a person feels strong emotions, they should be able to express that openly. As Glaser and Strauss so vividly demonstrate in their own work on death and dying, it takes awareness of a fact (e.g., that death is likely to occur, or in this case, that emotional repression is rampant) in order for a person to confront that fact.

The authors argue that confronting death requires allowing the patient to have an existential crisis of sorts, which needs to take place for patients to reconcile all of the effects that this information will have on them. This is also true for their loved ones who must also come to terms with the information that the patient is terminal, they will further need time to process how this makes them feel. By depriving the patient of a chance to face their own mortality Glaser and Strauss argue that you deprive patients of the ability to prepare, as well as to conclude the final moments of their life as they wish. Patients need to die *socially* before they die *biologically* (1965, p. *x*). In critical care medicine, there has historically been a hesitancy to freely express emotion in healthcare spaces due to the perception that it will only upset the patient and that it will damage your professional career as you will be viewed as being unprofessional and uncontrolled. But are these beliefs or facts?

> Multiple team members walked by the ICU doors and seemed to be gathering in our conference room. I tapped our team lead on the shoulder and asked, “What’s going on?” She replied, “We’re having a debrief for Angela.” “Wow,” I said, “there hasn’t been a debrief in a long time, that’s great news.” I wandered over and stood at the back of the room to watch. I could see a person from human resources on the projection screen on the wall, binder in hand, patiently waiting for everyone to quiet down. Finally, the team leader grabbed everyone’s attention, “We are going to begin okay,” she said, just as I decided I wanted to find a better seat. I gently pushed past some nursing staff to find a seat in the middle of the group. The team leader introduced the HR woman, saying that she was there to guide us through the debriefing process and explained why we were having a debrief. “She was so young,” the lead said, “and this case was really sad for all of us involved, especially the staff who were her primary caregivers,” she paused, “I would like us all to have a chance to talk about this case together.” The HR woman piped up, and said, “Now, I was not present for this case, and I don’t really know much about it or what happened, but please feel free to let us know how you are feeling.” The room was silent. The nursing lead spoke again, “I feel that we all did our best to manage this case as professionally as possible, and we developed a very good relationship with the parents… I also feel that it was just very hard to watch it all come to an end.” The room was silent again. Then, the ICU doctor spoke up. “I’ve been part of so many deaths over the years, and they are always sad, but you eventually learn to find ways to cope… this is something I’ve had to do in my own practice, find ways to not take these cases home at the end of the night,” he said. The room was silent again.

> A few more individuals spoke over the hour, including a resident and another nurse, when the HR representative decided to end the session. People began shuffling out of the room, and I heard a few team members say, “Well, that was bullshit,” or “That didn’t help at all.” I felt deflated and energized at the same time. Why did no one speak up about the heart of the matter, why were they all so closed off, and why did they use a woman from HR who didn’t even know the case? I felt angry. Just then, our spiritual care representative asked a few team members if they would like to engage in a short prayer at the patient's bedside. I am not religious, but I felt this act would surely be closer to honouring the patient than the session I had just participated in. I wandered over to the empty ICU bed with the chaplain, a few nurses, the pharmacist, the dietician, and the unit aide. We all gathered around Angela’s bed, she was only 15 years old when she died of a rare blood disorder in this very spot, and we lowered our heads in silence. The chaplain then gave a beautiful speech about the patient, her family, and how we will always remember caring for her, and the parts of her life that were not restricted to the ICU, such as her love for her pet cat and the stuffed animal she always had with her. A few tears were shed silently, and we all remembered her with sadness and joy in our hearts. He finally broke the circle, and we all shared a few memories of working with her. Then we slowly dispersed and went back to work. I finally felt a little lighter.

Glaser and Strauss astutely say that “If our report [their book] makes matters easier for people who must live around the dying (and vice versa), it will only be because critical intelligence is brought to bear on our findings and on common practices in American hospitals” (1965, p. *x*). In our case, the concept of awareness must be applied to the critical care setting to examine how this professional environment operates and the social and cultural rules that people are unconsciously or consciously abiding by. There are subconscious reasons (e.g., fears, beliefs, and thoughts) that govern our actions in the ICU, as well, there are cultural rules and practices that become habit, or second nature. To be aware of the hidden factors that contribute to our collective actions, we must make an effort to expose them and examine them closely. We need to ask questions like, “Why is tearing up in the ICU such a faux pas?” or “Why do we only have two debriefs a year in a place where people die every day?” and lastly, “What contributes to the silence on the unit?” If we do not ask direct questions about the nature of processing emotion in the workplace, we will simply continue to be unaware of these forces (social, environmental, and cultural) and continue repressing our feelings.

The most important thing to be aware of is our behaviours, which further require awareness of our thoughts and beliefs. When we think in certain ways, and we believe certain things (as if they were facts), this will affect how we feel, as well as our behaviour. If we consider the debriefing above, some of the thoughts I had during this session included: (1) “I felt so sad when Angela died. I walked past her bed, which I had done for so many days before today, and when I saw that the bed was empty a lump formed in my throat, I immediately knew she had died overnight;" (2) "Wow, Dr. Whiting is here (the senior ICU doctor), I don't think I want to speak in front of them, I might embarrass myself, it's better to keep quiet so I don't regret what I said later;" and (3) "Why didn't the team take time to create some psychological safety in the room before asking everyone to share their deepest feelings, you can't just throw people into this type of work, it's very sensitive."

If I had been blithely unaware of these thoughts, which contributed simultaneously to my feelings of sadness, anxiousness, and annoyance at the time – I would be ignoring important features of this situation that could have been addressed differently. We can also understand this process as slowly gaining and having self-awareness, or situational awareness, both are activities and skills that require time, patience, and practice to master. If you are like me – I have spent many years ignoring my feelings – this may take more time and effort than you expected. From my perspective, one of the best ways to gain awareness is to observe both the self and the environment. The next few sections are dedicated to helping provide outsiders with a clearer picture of what the ICU is like, both in spirit and in structure.

3.1 The Intensive Care Unit

Figure 8: Image of an empty intensive care unit room with the bed and monitors neatly prepped. Photo taken by Hillary Ferguson in the ICU.

> My colleague, looking sort of pale, said to me, “Oh man, you missed quite the case the other day… They opened the belly right here on the unit, and that doesn’t happen very often in ICU,” she said in disbelief. I looked at her reassuringly and said, “Oh wow, really? I can’t believe I missed that… Why did they do that?” I asked. She said, “The team didn’t have time to go back to the OR I suppose, it looked like they took the whole contents of the patient’s abdomen out and set it on the table, there was blood all over the floor, I’ve never seen such a mess… It was awful.” I could tell the sight had bothered her, and this instance reminded me of the necrotising fasciitis case I had experienced long ago. “Are you okay?” I asked her. She took a breath and said, “I think so, but that’s a visual that will probably be with me forever…” I commiserated with her and told her “It will eventually fade and become easier to process.”

Critical care *can* take place anywhere in a hospital where patients require life-saving interventions, resuscitations, or long-term care for critical injury or illness, but it is most often understood to be localised within intensive care units (ICUs). An intensive care unit (ICU), adult or paediatric, is an area within a hospital that has been reserved for the most critically ill patients. Critical care denotes exactly what it sounds like, in that this service deals with the aftermath of the most life-or-death scenarios of medicine. This generally includes patients who experience extensive trauma to their body from motor vehicle accidents, gunshot or stab wounds, or who are gravely septic or at the end-stages of disease (to name a few) and will normally be stabilised in the emergency department and then sent to the ICU for care.

Critical illness technically includes patients with “any life-threatening condition that requires pharmacological and/or mechanical support of vital organ functions without which death would be imminent” (Aminoff, et al., 2021). Critical care is necessary for ventilator-dependent patients, patients who require vasopressors or inotropes, or who are simply too sick (e.g. sepsis, organ failure, surgical complications, or trauma) and need twenty-four-hour care by medical teams, as well as what is referred to as one-to-one nursing care. ICU patients are typically admitted under staff physicians or intensivists, who are then responsible for their care, while other healthcare providers (i.e., surgeons, specialists, social work, spiritual care, etc.) visit the ICU as a consulting service to address any specialist gaps in care. This is what is known as a ‘closed unit’, whereby the intensivist is the primary physician responsible for all patients admitted to the ICU under their care, but they can use specialist services within the hospital to successfully enact the patient’s care plan.

This level of organising care has not always existed, and today the ICU probably represents the peak of medical expertise and is one of the greatest developments related to our ability to care for patients. The need for expedient or expert medical care has always existed for humans who find themselves facing a crisis of health or bodily integrity, and patients of any era would benefit greatly from the modern advancements of medicine today, however, it was simply not always available.

Surgical patients perhaps bore the main brunt of this lack of technology throughout the ages, since before the advent of anaesthesia, analgesia, or numbing agents like lidocaine, even tourniquet anaesthesia or nerve blocks, patients were expected to endure the pain of being operated on, whether it be burr-holes that were made in the skull (or trephination) during the neolithic period (Irving, 2013), leg amputations after battle (Shuster, 2009), or an auto-appendectomy in the Arctic (Bermel, 2009).

Diseases, as they have been understood over time, either as punishment for sin, an imbalance of the humours, or an alien infection of bacteria, etc., are perceptions that have shaped or inspired different approaches and/or theories of healing over the centuries, whether divine or mechanistic. Casualties of war also created a need for medical specialisation and the coordination of medical personnel and care. The history of critical injury and illness is as old as the human body itself, yet the history of planning and organising care around acutely or critically ill patients (from a Western perspective) is only approximately 174 years old (Huecker, et al., 2022, p. 418). In 1850, Florence Nightengale was one of the first caregivers to position patients, those who were severely injured in the Crimean War, closer to the nursing station in an effort to more quickly anticipate and deliver them "intensive care" (Ristagno & Weil, 2009, p. 4).

Seventy-three years later, Ristagno and Weil (2009) discuss how "in 1923, the concept of postoperative recovery was modelled by Dr. Walter Dandy who organised a neurosurgical postoperative care unit at Johns Hopkins Hospital in Baltimore, enlisting specialised nursing staff" and how later "This initial intensive care also became a model for postoperative recovery units, which provided intensive postoperative management for military casualties during the Second World War" (p. 4). As time went on, in the 1950's, it was the nursing staff and anesthesiology physicians who were "equipped with bedside monitors that triggered timely life support interventions and thereby improved management in the immediate postoperative interval" (Ristagno & Weil, 2009, p. 4).

Consequently, the practices that are now special to the critical care medicine that is conducted in modern hospitals are very deeply rooted in the practice of attempting to isolate all the sick patients in one place to coordinate resources, triage patients, and care for them promptly, which was also done as a response to the polio epidemic (Wheeler, et al., 2018, p. 276).

> "…[F]rom the devastating Copenhagen polio epidemic of 1952, which resulted in hundreds of victims experiencing respiratory and bulbar failure, over 300 patients required artificial ventilation for several weeks. This was provided by 1,000 medical and dental students who were employed to hand ventilate the lungs of these patients via tracheostomies. By 1953, Bjorn Ibsen, the anaesthetist who had suggested that positive pressure ventilation should be the treatment of choice during the epidemic, had set up the first intensive care unit (ICU) in Europe, gathering together physicians and physiologists to manage sick patients – many would consider him to be the 'father' of intensive care [because] Dr Ibsen had the

> idea of caring for all such patients in a dedicated ward, where each patient could have their own nurse. Thus, in December 1953, the speciality of intensive care was born" (Kelly, et al., 2014, abstract).

3.2 Delivering Critical Care

Modern hospitals have perfected this practice, having taken the art of organising hospitals around the need for specialised care to a whole new level, even beyond the need for segregation due to high levels of contagion. Most patients who are admitted to hospitals today are assigned (if possible) to hospital beds that are located on floors that provide the specific type of care that the patient needs. This means that the caregivers working on that floor are experts in providing this specialised type of care, e.g. thoracic surgery patients go to the thoracic floor and are cared for by nurses who are trained to monitor thoracic patients, and who are visited by thoracic surgery medical staff. Gone are the days when physicians were well-trained in almost all areas of medicine, e.g., performing surgical procedures, giving medications, delivering babies, and doing home visits; today, medical education is focused on specialisation.

This model of organising care according to service does help to coordinate resources, however; sequestering different types of medical care to specific areas of the hospital (or within different hospitals) also serves to cut off access to others. Patients who require cardiac medical care might be sent to one hospital to address their cardiac needs (e.g., open heart surgery), but if during their stay they develop a thoracic-related condition (e.g., esophageal perforation) that service (e.g., a thoracic or an ear, nose, and throat surgeon (ENT)) may only operate at another hospital site at a different location. This means the patient must be transferred to receive that care, or the surgeon must come to them. This is not always easy. For the surgeon, it could mean operating in a foreign place that is not ideally set up for that specific procedure. For the patient, this can create a delay in getting an expert to the patient in time during an emergency. If the patient must be transferred, this could put their health at risk if they are unstable. Hancock and colleagues (2019a) reference the stress that ICU nurses felt when trying to transfer critically ill patients to their unit during a flood at their hospital. They say:

> "So, for example, we took 3 patients that should never have been moved and moved them down the street and all 3 of them did very poorly. 1 died, and 2 became sicker over there…" "…they [the family] were running into the unit up the street to try and make sure they didn't miss the opportunity to say goodbye to their loved one which is ridiculous. That should never have happened, and the only reason it happened is because of compromising care due to cost-cutting. We're still in a building that's not functional" (p. 27).

Transferring critically ill patients is difficult since they are hooked up to ventilators, dialysis machines, and other forms of support. These patients are very sensitive to any changes in their environment due to such severe illness, so moving them only occurs if they are stable, and it is necessary to complete scans, operations, or other vital procedures. In the above example, a flood had occurred at one hospital, making the transfer to another hospital necessary. Managing sequestered resources and access to care can introduce stress and risk for all parties involved. For that reason, what happens outside of any one department can adversely affect others, meaning "operations cannot be optimised solely in one microsystem without potentially impacting operations in another microsystem" (Wheeler, et al., 2018, p. 277).

In keeping with the sequestered organisational model of care, critical care patients occupy special units of the hospital (ICUs) and are given unique privileges. Unlike most patients, who often need to share beds in an open ward, making compromises on privacy and comfort, the sickest patients in medicine need particular types of rooms that will meet their needs. Most critically ill patients require large private rooms to fit the extensive machinery for monitoring, allowing space for staff to perform bedside procedures, alongside delivering a host of other services, tests, and checkups, as well as people who must come to the bedside to deliver care.

Even though ICU patients tend to stay put, Wheeler et al. suggest that "four walls" do not make an ICU, reminding us that critical care is not restricted to this one department. They argue that critical care medicine stretches far beyond these four walls to include the emergency department (ED), the operating rooms (ORs), recovery rooms (or post anaesthetic care unit(PACU)), palliative care, chronic pain specialists, and intermediate care units (IMCU), to name a few (2018, p. 276). Constant levels of cooperation and communication must take place between these different units to ensure the proper flow of patients, beds, and resources; although, these transactions are not always smooth. Resources are often limited, and there can be a lot of disagreement about what the best course of action is in any given situation. Ethical dilemmas are a continuous part of daily life in healthcare, and there is a large amount of stress and uncertainty behind many of the decisions being made. The following is an example of this type of tension, taken from my experience working in the recovery rooms:

> *Ring ring ring…. Ring ring ring… Ring ring ring…* The charge nurse finally runs over and picks up the phone. "PACU, Nelly speaking… Hello?" she says as she untangles the phone cord from the computer monitor and simultaneously prepares a syringe to draw a blood gas. On the other end of the phone, a gruff masculine voice replies, "Yes, this is the bed manager, I heard you have a patient who might need to be ventilated overnight?" "Yes, that's right," says Nelly, "We already have a take-back to the OR, the patient was bleeding extensively post-op, and we have another patient who destats every time we pull the tube out. We don't think they'll be ready to be off the vent for a few hours' minimum, and there's only three of us down here." The bed manager pauses… and finally says "Well, they are pretty tight in the ICU, they

> have no beds down there right now… Their charge nurse said they need to keep their last bed open for emergencies… So, you'll have to call someone in, that patient isn't going anywhere anytime soon." Nelly hangs up the phone, now becoming frustrated. "Yes Evan, I see you," she yells to her colleague who is now caring for four patients alone, "I'm coming over to help you!" She assures him as she considers her options. *God, I wish ICU would just help us out every once and a while,* she thinks to herself.

I cannot count how many times I have experienced disagreements between caregivers who are both well-intentioned and who are trying to do the *right* thing, but who cannot seem to agree on a course of action. A common trigger for disagreement is when two departments need to deal with each other, and they have what they perceive to be conflicting needs. Each medical unit has its own patient population, protocols, and their own cultural rules, and they operate to 'protect their own'. Hancock, et al., quote an ICU physician who says "…We are all expected to play in the same sandbox, but everyone's playing with a different set of rules…and we can't control the rules the other people are playing with" (2019, p. 27). When resources are short and when situations become unpredictable, it can often be a source of tension when one medical unit says "no" to another, for self-preservation and to protect their patients. Dean, Talbott, & Dean (2019) argue that:

> "Too often clinicians are pitted against one another as resources shrink. Doctors compete with each other for referrals, advanced practitioners and nurses compete with doctors, and everyone feels overstressed. What we tend to forget is that we are all working toward the same goal: To give patients the best care possible. It's time to view each other with the presumption of charity and to have each other's backs. Uniting for support, camaraderie, mentorship, and activism is a necessary step in making change" (p. 402).

In my experience, the hostility seems to come from a deep sense of wanting to help your *own* patients, but it can also be explained by the term *othering*, especially when staff proclaim (about the other units) that "they don't understand us," "they just don't like us," "they don't care about us," etc. [34] An ICU staff member in Nova Scotia was quoted as saying "I mean think about it, you've got to deal with a very, very sick person and you've got nowhere to put them and you're there on the floor trying to make this person stable enough to survive you getting another patient up to PACU"

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[34] According to Akbulut and Razum (2022), "othering" develops as a way to distinguish members of a belonging group, versus those who are outside of that group, or are other than those who belong. They write that "There are many terms that describe who belongs, and who does not belong, to a group. These various social distinctions of belonging depend on constructs of differences. They permit social classifications into which certain groups are categorized, often as binaries or opposing pairs; examples are migrants and non-migrants, or regular refugees and irregular refugees. By using these terms, we construct different narratives of the Other, thereby signifying non-belonging" (p. 1).

(Hancock, et al., 2019a, p. 27). There is not always a straightforward solution to these dilemmas, since beds are finite and it sometimes comes down to who is going to win out in the end, who deserves to have the bed, who is sick enough, or who will make the best case. These are ethical questions that sit heavy on the conscience of decision-makers.

Further to this difficulty, due to the nature of care that is provided within the walls of an ICU, death is a common occurrence; and it is not always a nice death. Healthcare teams cannot always predict where or when a patient's health will dramatically decline, meaning resuscitation efforts might need to happen elsewhere in the hospital, e.g. on the OR table, in the transport vehicle, on the ED gurney, or in the hallway after a CT (computed tomography) scan – what this means is: outside the safety of the ICU. Additionally, end-of-life care is not only performed at the very end of life, but it can also take seconds, minutes, hours, or days, in rare cases, years. For this reason, patients are often sent to the ICU for aggressive or life-saving care, or sometimes simply to have a place to die. In keeping with the specialised training and experience of intensivists and ICU nurses, the ICU is considered best equipped to provide these services. This fact raises the likelihood that ICU providers will have to deal with the majority of hospital deaths.

There *are* other places where patients can die, however, palliative services are scarce and may not be readily available; the operating rooms are not an appropriate space to say goodbye (as this is a sterile zone that traditionally prohibits family members); and the emergency department is tasked with having to quickly move patients out to make room for others who are incoming. ICU staff are then primarily exposed to some of the most difficult care performed within the hospital, including cardiopulmonary resuscitation, having end-of-life discussions, using invasive technologies to extend life (e.g., extracorporeal membrane oxygenation (ECMO)), and being involved in post-mortem care (e.g., removing tubes, lines, gowns, washing the body, and putting them in the body bag) (Mealer, et al., 2012, p. 293). These facts contribute to making critical care staff particularly prone to burnout, moral distress, and high rates of attrition.

Out of the many ICUs that function in my area, I have worked in three of them, including a medical-surgical-neuro ICU, a cardiovascular surgery ICU, and a medical-surgical ICU. I have no experience working in a paediatric or neonatal intensive care unit or PICU/NICU, my only experience is with adults, and some younger adults around the ages of 14-18 years old. The hospitals in which I worked were the most tertiary or quaternary care facilities in my area, i.e., those that give the most complex and comprehensive care to patients who need trauma, emergency, and/or intensive care medicine. Each hospital was, however, somewhat sub-specialized. For example, one centre had the only emergency room nearby and was the primary location to admit and treat patients who required neurological surgery or monitoring, whereas another site delivered cancer care and transplant services. This meant that patients who were admitted to one hospital presenting with either neurological issues (e.g. traumas, suicide attempts, or overdoses) or needed a transplant, would often be transferred between the sites to receive that specialist care.

3.3 The Structure of the ICU

Although ICU admissions/discharges/readmissions and deaths are highly unpredictable, the daily operations of an ICU are quite routine. A day in the ICU is structured predictably, and despite many unknowns, some factors are consistent. Two intensivists staff a unit of 10-15 beds during the day and night (i.e., shift work) and are responsible for overseeing the medical care for all patients admitted to ICU. Residents and medical students (those on rotation for education) are always assigned to the ICU for a few weeks and can be at the hospital as early as five am in the morning (if they have not already been there all night long). They arrive to "round" on patients (i.e. assess them medically), connect with the nursing staff from the night shift, talk to the intensivist working on the unit that week, write new orders, do procedures, and prepare for ICU rounds which begin at 9 am.

ICU rounds are when the interdisciplinary team members (i.e. physicians, residents, nurses, pharmacists, dietitians, respiratory therapists (RT), etc.) who work in the ICU huddle around each ICU patient's bedside to review their medical history and modify the current care plan. The process of reviewing each patient's care is very thorough and includes a review of the patient's night in ICU, their experiences with the nurse until 9 am, and an outline of each bodily system and how it is functioning to date (e.g. neurologic, cardiovascular, gastrointestinal (GI), genitourinary (GU)). Patient labs, scans, past surgeries, and procedures are all reviewed and outlined orally by the team. Each member of the group will contribute vital updates regarding the patient's status, and modifications to the patient's daily care will be made in accordance with this information. Rounds sound something like this:

> [Resident Physician] Hello everyone, Mrs. Smith had a pretty quiet night. She is 66 years old, is a full code, has no known allergies, and she is post-op day ~1; although she technically only arrived at 1 am overnight, after a left-sided pneumonectomy. She was a heavy smoker for 30 years, approximately a pack a day, and suffers from congestive heart failure, hypertension, and diabetes. She was diagnosed with pleural mesothelioma and underwent a radical pneumonectomy yesterday and was brought back to the OR late last night for bleeding.
> [Primary Nurse] Her vitals are looking good, she has been afebrile this morning, her heart rate is slightly elevated around 120, her MAP is 80, and she is showing some signs of atrial fibrillation. Her chest tube is still in place and clamped, we check it every hour. According to RT, we feel she's ready to be corked this morning and put onto NIV. She's not on any pressure, she has a right-sided central line and an art-line, her belly is soft she has good bowel

> sounds, and her urine output is normal… etc. [*The rest of the team would contribute their expertise in sequence*].

RTs will outline the respiratory efforts of patients and help to determine whether patients are ready to breathe on their own (i.e., be extubated); pharmacists will review the patient's medications and propose ways to coordinate the patient's pharmaceutical needs in line with the care plan; and dieticians will monitor the patient's ability to eat or drink, and address their special nutritional requirements while on the ICU as patients might be intubated, sedated, overloaded with fluid and edematous, or are fasting before surgery, all of which are factors they need to consider. ICU rounds are usually completed around twelve, in which case team members will grab lunch if they can. Otherwise, the decisions made during rounds will then be enacted, such as any scans, procedures (e.g., surgeries, lines, catheters, dialysis, ECMO), or changes in care that need to take place will be undertaken.

Registered nurses (RNs) working in the ICU do rotational shifts, which are usually twelve hours long and occur anywhere from three to five days a week, since ICU staff may choose their own schedules. They work dayshifts from six-thirty-am until six-thirty-pm, and nightshifts from six-thirty-pm until six-thirty-am (the half hour on either end is used to give a "report" to the next nurse coming on shift). Staff physicians or intensivists work a full seven days in the ICU beginning on Friday afternoon at four-pm and finishing on Friday afternoon at four-pm the following week. They show up in the ICU early in the morning, as early as 5 am, and are relieved by an evening physician around 4 pm each day. Starting on Friday at 4 pm they are on-call 24/hours a day until Sunday at 4 pm when the evening physicians begin their first shift. Residents rotate throughout the ICUs, staying on the unit for approximately one month, doing two weeks in one ICU and then moving to another ICU for another two weeks, to diversify their learning.

Further support staff also do shift work, such as the unit clerks, housekeeping, unit aides, and continuing care assistants (CCA's), etc. who work as caretakers for all ICU patients and support the staff working on the unit. The ICU is often visited by many external services such as nephrology, surgery, transplant, anaesthesia, acute pain, internal medicine, infection control, and pastoral care, to name a few, so there is a lot of coordination required. All ICU care is directed by the primary intensivist on the unit, since it is a closed-unit model, and consulting services (as listed above) will administer and coordinate care in collaboration with the entire ICU team. For example, patients may be admitted to the ICU, but they can still travel to the operating room (OR) to have surgery which puts them under the care of surgeons and anaesthesia staff, or they may leave to have a CT (computed tomography) scan or MRI (magnetic resonance imaging) putting them in the care of radiologists (interventional or not).

This fact is important to note when it comes to understanding the ethics and politics related to do-not-resuscitate (DNR) orders, as patients may be under the primary care of ICU doctors, but they may not always reside specifically in the ICU area when they experience a change in their health status and may need to receive emergent care from other providers during their stay (e.g., resuscitation by anesthesiologists in the OR). Patients also frequently become "declassed" a term used to denote the improvement in the patient's health, and therefore, a downgrading of medical need. Declassification means that they no longer require critical care monitoring and are "reclassified" or assigned to an intermediate care unit (IMCU) or the nursing floor. Even though some patients do leave the ICU and never return, many of them will transfer out of the ICU only to be readmitted shortly after if their medical needs increase again (e.g. a patient who recovers, but then later suffers from respiratory failure and requires intubation).

Intensive care medicine is thus not comprised of four walls alone and indeed requires extensive collaboration and cooperation from all units of the hospital. The ICU is also highly reliant upon external support services such as paramedicine, and emergency health services (EHS) (both ground (i.e. ambulances) and air (i.e. life-flight)) to transfer patients from the scene of the incident, or between the different hospital sites, and from any ED.

3.4 The Culture of the ICU

Critical care units share important similarities and differences. In locations around the world, every ICU will have varying capabilities by virtue of their hospital policies, their resources, and their governance. In other words, some ICUs may have more resources or technology than others, and even if the degree of expertise and technical capability is variable, ultimately, all ICUs intend to deliver a similar type of care (e.g., ventilation, monitoring vitals, or use of vasopressors/inotropes). Obvious deviations from this will be in countries that have very little funding, or areas that are disrupted by sociopolitical occurrences like war. Currently, the war in Gaza is ongoing, and one news reporter paints a grim picture of their intensive care, "Mohammed Baalousha, a journalist with the Emirati TV channel Al-Mashhad, said he found the decomposing infants when he entered the pediatric ICU in the health facility in Gaza City. The hospital's staff and critically ill patients were forced to evacuate in early November as the Israeli military focused its ground assault on the city, with hospitals under fire" (Salam, Abdelkader, & Mulligan 2023).

The ability to receive high-quality life-saving treatment and care where you live is an experience that not all citizens are granted. The Covid-19 pandemic also highlighted this fact when ICU beds and ventilators needed to be fairly allocated, and patients needed to be triaged (Wang, 2022, p. 715). Fowler et al., (2015) explain how "There is substantial global variation in the capacity to provide critical care" given various resource demands (p. 1), and "Previous estimates using national health administrative data indicate that Canada has far fewer ICU beds per capita than the United States, but similar numbers of ICU beds to those in many Western European nations" (Fowler, et al., 2015, p. 1). They further explain that "Because healthcare is a provincial portfolio in Canada, differences in provincial priorities may translate to differences in availability of specific resources. Moreover, because critical care services represent one of the most expensive components of the healthcare system, the cost is an additional reason for regional differences" (Fowler, et al., 2015, p. 2). In addition to regional and operational differences, the culture of critical care units will vary.

Despite the degree to which all ICUs share both a procedural and institutional likeness, every ICU environment is unique. Critical care teams utilise machines, medicine, and technology, but they are primarily made up of people, more specifically, communities of people. Such communities exist and operate within specific hospitals, and in specific towns, and even smaller subpopulations exist on the wards of these hospitals, each having its own cultural and historical ways of doing things. The hospitals I have worked in are home to such subpopulations or subcultures of people that make up the critical care environments. The struggles that these individuals face by working in different ICUs are sometimes shared, although they are often unique due to both the type of care delivered (e.g., a cardiac ICU versus a neuro-ICU) and the specific patient populations they serve (e.g., chronic cancer patients, versus young trauma patients).

The social habits and innermost circles of an ICU are determined both by individuals and collectives, as well as by current social climates and past histories. In other words, as different people come together in a workspace, they will affect each other in different ways. Specific people can influence the moods and responses of others and contribute to the emotional dynamics of the unit day to day, meaning the various permutations of individuals working in the ICU at any time will affect the social atmosphere. Similarly, different professional groups will interact differently in the ICU, and even though everyone is a 'part of the team', the nature of one's role is subject to the social hierarchy (e.g., the unit aides may be treated differently than the nursing staff). Thus, the ICU culture is fluid and always changing. Some changes are subtle, say the shift that is noticed when a veteran nurse retires or when new nursing students arrive at the ICU fresh out of the Critical Care Nursing Program (CCNP). Other changes can be more dramatic, such as the new protocols that arrived alongside the Covid-19 pandemic, the massively high attrition rates of nurses during this time, and the increased risk of treating such highly infectious and vulnerable patients.

ICUs are further shaped by the care they provide and the relationships that are formed within the hospitals in which they reside. For example, a postoperative cardiovascular intensive care unit will be shaped simultaneously by the cardiac care they provide, influenced by the cardiac and vascular surgery cultures that they enmesh with, and the cardiologists and intensivists that run their unit. Hospital cultures cross over and intermingle with each other, but they are at the same time somewhat distinct at any given time; they are marked by the names of their hospital ward (e.g. PACU), and by invisible lines that have been socially and sometimes literally drawn throughout hallways, those that mark entrances and exits to areas (e.g., doors, walls, passcodes, and restricted access). Since the ICU is a closed unit, patients and families have to call the ICU desk before entering to visit, giving this unit a literal gatekeeper.

Hospital staff can float freely between the units but will usually carry a badge to indicate their role in giving care, e.g., symbols that spell RN or that say Physician. Some of the units on which I have worked shared a hallway, resources, staff, and patients, but their respective cultures were completely different from each other. They had built a shared identity that represented their community and the role they played in delivering care; they were *x* department, *x* people, and fought for *x* rights. Some units were also shaped by the patient population they served, for example, one unit often received very difficult patient cases such as the victims of shootings or suicides, motor vehicle collisions (MVCs), patients with trauma to the body from heavy machinery or natural insults (such as forklifts, or the occupational hazard of working near trains, on boats, or as a firefighter). These patients can be very young, sometimes as young as 16 years old, having been admitted with little chance of survival. Other units might care for a completely different patient population, those who are older, chronically ill, and riddled with cancer or plagued by organ failure, where the dying process is long and drawn out.

The differences between these types of patient populations affect the staff in various ways. When aggressive interventions are performed (if they are consented to by the family and are warranted), these measures can be lifesaving; however, they can also be upsetting for family and ICU staff to watch, as they have to witness both the sad nature of the injuries experienced by the patient alongside the painful and invasive care that is performed on them before death. CPR is poorly portrayed on television, as the resuscitator gently pushes on the person's chest to revive them. CPR actually requires a lot of force and literally bounces a patient’s body on their bed as high as a foot or more, and their ribs sometimes break under pressure. CPR is also exhausting and requires a lineup of individual practitioners ready to push, they trade off after one becomes tired. Units like this one are marked by high levels of death and dying, and the staff attitudes and coping strategies are reflective of this. The type of care that is given here is expected to breed high rates of attrition, and as already discussed at length, secondary trauma, burnout, and moral distress.

> It was 6 am, dark, and moody on the streets. I was walking to the OR, my shift started at 6:30 am and I liked to be early. I always got up extra early so that when I arrived, I could take my time putting on my scrubs, tucking my long hair under my scrub hat, and ensuring that I had my identification badge and a pen in my pocket. Pens were scarce at the old hospital, and it was no joke to forget your pen, if you didn’t have one you were literally ‘shit-out-of-luck’. My walk was so quiet, there were no cars, no pedestrians, just the dim glow of the streetlights and the empty pavement still glistening with moisture. This was a peaceful time of day, but it also made me nervous as a woman. As I quietly made my way down the road, I was vigilantly

aware that this can be a dangerous time of day, and I made sure to notice if anyone was around me.

Halfway through my walk, as I passed by the newer hospital, I looked up at it nostalgically, as I often do, acknowledging how it was like a second home to me – a place I felt comfortable and enjoyed being. Suddenly some shadows moving in the windows on the fifth floor of the hospital caught my eye. It stuck my attention because only some floors had lights on at this hour. I squinted my eyes as I searched the shadows, it looked to me to be nurses running around a patient's room. I counted the floors of the building, and knew it was the ICU. I then recalled a particular patient in the ICU who was admitted the prior evening, they had been traumatically injured and were not very stable. "I think that's their bed by the window" I thought. Just then, I could see in the silhouettes in the window moving up and down rhythmically, as they pounded compressions. I felt a pit in my stomach as I reconciled what the shadow play was portraying. I had never witnessed CPR from this angle before, and I felt helpless on the streets below watching. It was an eerie sight. All I could do was send this patient my thoughts and prayers, just in case. Sure enough, when I arrived later in the evening to the ICU, I collected the patient's chart who had been declared dead at approximately 6:35 am. I brought the haunting image from the morning back into my consciousness, and whispered, "I am sorry this happened to you."

Figure 9: Adobe stock photo, royalty-free, Dec 22, 2020, "The exterior of the hospital building at night. Aerial view of the windows of hospital wards in a clinic" from: https://www.google.com/imgres?imgurl

One of the hospitals I worked in specialised in what are called “ENT flaps” which is a shorthand way of describing patients who require oral-maxillo-facial surgery to address cancer of the mouth, often due to a history of smoking or drinking.

> I watched the liquid jars out of the side of my eye, weary of their contents, but vigilantly watching to ensure their enclosure was well-fastened. I felt sick to my stomach, and like there was something on me. I never thought I would have to see leeches again since I decided to stop swimming in the lake at my family's home. Disgusting squiggly black flatworms that balloon up once they’ve gorged on your blood. I hated the thought of them on my leg, let alone in my mouth. These leeches, which were swimming around in the glass jar beside a patient’s ICU bed, were being used therapeutically. Oral surgeons used them to draw blood through the newly grafted vessels of the skin graft these patients had received to patch the hole where the cancerous mass had been carefully excised from their mouth.
>
> I had thought our bloodletting days were over, but apparently not. I stared at the jars in utter horror, the charge nurse smiled at me as she said, “You look like you’ve got the heebie-jeebies!” I stared at her with my face slightly contorted, unwavering in my disgust. “I am not going anywhere near bed 5 today,” I replied. She laughed loudly, and said, “You get used to them after a while, but they can be pretty gross to deal with!” I shuddered as I tried to ask her a question, one I knew I did not want the answer to, “Um, di- did... do you pack the throat at least? To make sure they stay *only* in the patient's mouth?” She looked at me confidently, and said, “Don’t worry, gastric juices kill them.” Almost gagging, I said, “Oh my god, that was not the answer I was looking for!” She laughed again, “Yes, we watch them carefully! Don’t worry so much, it helps the patient in the long run, it’s better than the flap dying.” “I don’t know...” I said now smiling, “If this ever happens to me, you can let me die of oral cancer.”

Patients can also sit in the ICU for days waiting to see if they might get on the liver transplant list; staff must watch as these patients turn yellower, sometimes even light pistachio green from jaundice. They may never receive a transplant and die in the unit. Haematology patients are a group of patients that frequent the ICU, as they can often suddenly experience a decline in their health that will result in needing haematological or immune support for conditions such as thrombocytopenia, anaemia, or leukocytosis, they may require plasmapheresis, ventilatory support, drugs to manage their blood pressure, or they may come to receive palliation. I recall witnessing a few very young girls die from haematological deaths.

The deaths that happen in ICUs that care for chronically ill patients are upsetting in a way that is different from the sudden traumatic death of otherwise healthy individuals, instead of the shock and horror that can follow a traumatic injury and death, caregivers on these units get to know these patients much more intimately, and they learn their families' names, their hobbies, and spend great lengths of time caring for them. When these patients die there is a lot of sadness that surrounds them, and even though the patient's death is somewhat expected, the experience is still quite cutting, since these patients had to slowly succumb to the devastating effects of chronic illness and suffer the pain, treatments, constant interventions, scans, intubations, surgeries, and endless lines, all while wasting away in a bed they could not escape from. These are some examples of how the 'type' of patient care can affect the culture of a unit.

3.5 The Demands of Medicine

For those who are not intimately familiar with medical wards, operating suites, or ICUs – I will say that it can be very frustrating to watch excellent caregivers work hard to help patients and fail to provide them with good care, not because they did not try, but because they were blocked by systemic factors like ineffective protocols, outdated policies, contradictory rules, or strict regulations. This may also occur due to a lack of equipment or access to resources, and even because of disagreements with colleagues. Sometimes completing the simplest task can feel like climbing Mount Everest, and just when you think you have finally reached the top you find out that you still risk being frozen in the snow and ice. I often used to feel this way when trying to advocate for patients who were booked for surgery.

> The rush of the operating rooms is constant. Upon entering you are immediately absorbed into the fray, passing nervous patients and hurrying staff. An operating theatre runs on efficiency, and the success of a day is measured in units of time. A good day is marked by zero cancellations and few emergencies. However, the nature of this environment is unpredictable. Superstition runs rampant, and all fates remain undetermined. The diligent and passionate staff are unwavering in their focus. They work tirelessly and obsessively over the tasks presented in front of them, some moving chaotically throughout the OR, others barely moving for hours (e.g., a neuro- or micro- surgeon may not even look up). The hours pass by unnoticed until the charge nurse finally presents the surgeon with an ultimatum - to finish the case or to send the patients who are still waiting home.
>
> Surgical patients are always hungry because we require them not to eat for hours leading up to their surgery, which can be longer if the surgeon feels they might fit their surgery in at the last minute. "Just a few more hours until we know what's happening. Please don't eat or drink anything, I will be in touch soon," I would tell those who were still anxiously waiting. I knew that the wait could be arduous. On this particular day, towards the end of the OR's timeframe, there was a single plastic surgery patient still sitting in the waiting room, having

heard nothing from us for seven hours. I had my eye on the clock since she arrived, counting down towards her cancellation, as it is common to end up sending these patients home after a long day of expecting to have surgery. Every hour I would ask the charge nurse or the OR nurses where this patient stood in the queue. No one had a clear answer. The anaesthesia coordinator said to me, “Don’t worry, she’s not urgent.”

I pictured her in my mind, pacing back and forth, certainly cold, uncertain as to what was going on behind the scenes, famished and frightened by the precarity of her situation. Eight hours now. Still nothing. I begged the resident to go speak to her, as I had done many times throughout the day, but they kept repeating, “I’m busy right now, but maybe later.” Nine hours. Still nothing. It bothered me deeply because I felt she had a right to know why she was waiting. The place was quiet, it was now ‘after-hours’ with very few staff around. I was mostly alone, in between surgical bookings. I finally decided I needed to intervene. I forwarded the OR phones to my cell phone, marched past the empty surgical rooms, and weaved my way through the maze of recovery room patients and doorways to find the waiting room.

I entered to see only a single patient; she was the last one there. She turned in a hopeful manner to face the first person she may have seen in hours. I immediately felt guilty, but I was unwavering in my determination to tell her why she had been made to wait so long and what the status of her appointment was. I explained how things worked in the operating rooms and tried to reassure her. She seemed pleased to know – and I felt relief in telling her. I realized in that moment that patients want to *know* what is happening behind closed doors, and that knowing can be a major comfort for them. I felt satisfied, if only for a short time. Ultimately, another emergency case was soon booked for the same surgical suite and my efforts were for nothing since she ended up being sent home anyway. The next shift I knew I would try again.

This story outlines a single feature of my eight-hour shift, and in total, this event probably only took fifteen minutes of physical labour out of my day (i.e., speaking with the surgical team and the patient). However, the mental and *emotional load* (or the behind-the-scenes work/energy I expended managing the possible scenarios that could play out, and through planning and worrying about this patient) was consistently present throughout my entire shift. My awareness of this patient was intentional, and my concern for her was genuine, meaning, I knew I had to continue to advocate for her, and I had to plan for her possible surgery or cancellation, but I also had to ensure that I was addressing the hundred other tasks that required my attention that night, which included adequately tending to the other 19 OR suites that still needed coordination. It was not uncommon for me to worry about, stress over, or concern myself with five to ten difficult scenarios in the OR in a single day or night, nor was it uncommon for multiple patients to need your help that evening; meaning, the physical, mental, and emotional load for each shift was consistently high.

Healthcare systems are also politically influenced, and the people within them are socially accustomed to behaving in a way that is likely conducive to mental, physical, emotional, and moral suffering. These ways of suffering are both features of medical life (i.e., dealing with illness and injury), but they are also born out of medical education, medical mentoring, and the continuous erosion of the integrity and trust between caregivers, all factors that can alienate workers. The following discussion will be on phenomena that we need to be acutely aware of to address harmful cultural practices. If medical education has a part to play in supporting the current culture of medical institutions, which may unintentionally fail to treat their students and staff humanely, then this is important to know. Implementing wellness strategies in medicine also takes time and effort, and even though institutions are changing for the better, the influences of the past are still present. According to a systematic review of the literature by Seo et al. in 2021:

> “The burnout epidemic among medical trainees was only recently acknowledged. In the 1990s, the ‘Triple Aim’ of healthcare was established by healthcare institutions and organizations in the US. This new initiative emphasized patient satisfaction, quality of care and cost reductions. It was not until the 2000s that staff and healthcare provider satisfaction was formally considered in the rebranded “Quadruple Aim” of healthcare. In 2015, physician groups in both the United States and Canada began to adopt formal campaigns recognizing the resident burnout epidemic. In Canada, the 2015 CanMEDS Physician Competency Framework outlined that, in order to be a professional, one must have a commitment to self. In response, an increasing number of residency programs have restructured their training to provide and foster specific skills and dispositions towards work-life balance and self-care. Institutions have begun exploring a vast array of health-promotion programs including mindfulness, yoga, self-hypnosis protocols, small group debriefing and stress-management programs, curricular changes, evaluation changes, time management programs, reflective writing sessions, and self-development groups. However, recent literature on therapeutic stress management programs for medical students and residents have revealed mixed and inconsistent results, with overall unclear long-term benefits. In response, medical schools and residency programs have begun exploring alternate wellness interventions, aiming to prevent burnout long-term by fostering trainee resilience (Seo, et al., 2021, p. 2).

If we consider medical education, “Students have been found to experience difficult situations during work-based learning that will have a significant impact on them and produce strong emotions” (Lönn, 2023, p. 1558). Medical training is demanding and arduous. Rigorous aptitude tests (such as the Medical College Admission Test, or MCAT) are required for acceptance to many medical schools in Canada, where large complex bodies of information are introduced to students at break-neck speed. Early in training, exposure to patients in hospital settings can be traumatic to witness (e.g., motor vehicle collision victims), and tackling difficult interactions requires skill, tact, and patience (e.g., caring for the patient who swears and spits on you, or the homeless patient who is covered in maggots). Lönn and colleagues explored Swedish medical students’ experiences in relation to emotional challenges using narrative data from students' reflective essays, and they discovered that "students' main concern when facing emotionally challenging situations during their work-based education was the struggle to achieve and maintain a professional approach" (Lönn, 2023, p. 1557).

Similarly, residents are asked to work extraordinary hours and are saddled with huge amounts of responsibility. As their medical education continues, they may be more experienced, but they are also expected to handle more. Despite any sense of responsibility, learners are always at the mercy of senior staff, whether it is a veteran charge nurse, a senior resident, or a staff physician, all of whom are tasked with acting as supervisors, teachers, and mentors. Ideally, medical mentors are a guiding light within the storm of paperwork, consults, uncertainty, and resuscitations; although, at times, they can instead make students feel vulnerable, even embarrassed or demeaned, as the culture of medicine can be cruel and unforgiving. I will never forget a passage of Dr. Philip Stahel's book *Blood, Sweat, and Tears*, where he describes trying to call the staff physician in ICU late at night because he suspects his patient is bleeding into their belly, but the staff physician hangs up on him multiple times. He recounts how:

> "Finally, at 7am, Professor Gassner burst into the ICU, as he pushed past me, I attempted to brief him, but he barely listened. When he saw the patient, he became livid. 'Why the hell didn't you call me earlier?!' I would not have a sufficient answer. I was mortal after all.... 'There is no time," Professor Gassner shouted as he took charge of the situation like a commanding general. 'We have to open his abdomen now'. I held the retractors while he filleted open my dying patient's gut right there in the ICU... 'Anastomotic leak...' he said bluntly. 'You should have known.' After an hour of surgery, my patient flat-lined" (Stahel, 2016, p. 8-9).

Senior staff themselves are not immune from mistreatment in their careers either. These individuals are often left with the harsher realities of responsibility since being the primary responsible physician or caregiver means that you are also responsible for any fallout related to the patient's death or going through the litigation process. Many senior staff will have accrued a significant degree of expert and tacit knowledge, but this does not ensure their decision-making tasks will be straightforward, and ethical dilemmas are still a common occurrence in any healthcare setting. Consequently, providers may not know the correct or best course of action, which can create decisional uncertainty and emotional upset (or moral distress). Further to these assaults, all medical providers share the heavy responsibility of caring for people (even saving their lives) without making perilous mistakes, a weight that is put onto their shoulders daily.

Senior staff have been especially subjected to medical education that was devoid of compassionate training, mindfulness work, or self-focused care.[35] A news article taken from The Association of American Medical Colleges (AAMC) illustrates this point very well, the author writes:

> "When Darrell Kirch, MD, was 20, he witnessed an excruciating scene. Kirch, now 73, was working on a surveying crew in Colorado's Rocky Mountains when a 40-passenger plane suddenly crashed into the mountain above. A survivor came stumbling through the trees, his clothes and skin badly charred, and the surveyors quickly fashioned a makeshift sling to carry him to safety. Then they ran back to the scene to help others— but to little avail. Ultimately, 31 passengers perished. Kirch, who later became a psychiatrist and a leader in academic medicine — he served as president and CEO of the AAMC — says that today a psychological debriefing would follow such an event. "Back then, this happened on a Friday, and I just went back to work on Monday" (Weiner, 2023, para. 7).

It was not until the Covid-19 pandemic that I began to feel that the everyday struggles of healthcare providers were noticed, as news articles and broadcasts began to draw the public's eye directly to hospital wards like the ICU as well as nurses and other caregivers (e.g., those working in nursing homes or long-term care) giving them a more appropriate global spotlight. It is important to remember that the symptoms of emotional labour and burnout are not new, and the difficulties faced by healthcare providers are well-ingrained. One can now look back on articles published before the pandemic (e.g., Mudallal, Othman & Hassan, 2017) to see how the nursing shortage and issues related to nursing retainment including "unrealistic job expectations, poor work conditions, work demands that exceed resources, poor collegial relationships, increased work hazards, and poor autonomy and control over practice" are long-standing (p. 1).

The pandemic created an even more pressurised environment where difficult medical decisions became even more stressful, and where there was less time to be cautious, given all the uncertainty and fear. Under the pressure, I witnessed a nurse transition quite suddenly from being extremely calm, recording their patient's vitals and bustling around their bedside, to bursting into tears exclaiming that they "just need to eat!" They repeated this sentence a few times as they sat down, cradling their head, tears falling on their nursing note. Their co-worker did not even show surprise at this outburst, and simply said "Okay you can go to break." A curious physician, who heard crying, asked "Is that the family member of a patient?" to which the nurse replied, "No, a fellow staff member". This type of reaction is not entirely alien to an ICU environment, but it is certainly more akin to what we might call the Covid-ICU atmosphere. This happened two years into the Covid-19 pandemic, a time when

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[35] In Canada and internationally, programs have been slowly transitioning to a competency-based medical education (CBME) framework to reform residency training. This involves frequent and low-stakes workplace assessments of competencies which are felt to be required for independent practice, called "entrustable professional activities (EPAs)." "Typically, each EPA integrates multiple CanMEDS milestones as we use multiple abilities simultaneously when performing professional activities (e.g. we use our medical expertise, but also our communication skills)" (RCPS, 2023).

nurses had already endured many waves (a colloquial term used during the pandemic to describe the sudden spike in cases of Covid) of high patient admissions.

Medical students enrolled during the Covid-19 pandemic have had to face further difficulties in transitioning their learning online, as well as having fewer opportunities to enter hospitals or clinics to gain tangible medical experience. This was detrimental since the years spent in hospital gaining tangible medical experience is time that these students will never get back. In 2020, Dhillon, Salimi, & ElHawary reported how the pandemic "altered medical students' learning experience as the undergraduate medical education (UGME) office has adapted the medical curriculum and delivery methods in order to comply with social distancing guidelines set forth for Covid-19" (p. 1). ElHawary, et al., reported in 2021 that out of "248 medical students from 13 schools across Canada" who participated in their study, "74% reported a reduction in the quality of their education since Covid-19 [and] 58% of students found online to be inferior to in-person teaching" (p. 92).

The medical students at my local hospitals were considered to be extra bodies or what we might think of as non-essential staff (since learners often have mentors or supervisors) who needed to be protected from the inevitable spread of Covid infections in hospitals. I can recall week-long periods in the ICU where intensivists were burdened with completing an entire day's work alone – without the help of medical students and residents – who normally make up a core part of the healthcare team. Residents and medical students working in the ICU often assist staff physicians by rounding on patients, reviewing charts and medications, ordering scans and procedures, completing paperwork, and monitoring the daily care of all inpatients admitted to the ward. When things calmed down, staff were still subject to being exposed to the newly evolved coronavirus strains, in which case, all staff who had interacted with an infected person were expected to stay home and quarantine, bringing the numbers of students and staff rapidly down each week.

The inherent difficulty of medical life is not a highly contested fact, and I use many examples to demonstrate this in my project, but I also want to point out that it is not *all* bad. Most medical providers are drawn to the work they do for a reason, and many of them view it as a calling. Medicine is considered a field of service that requires heavy amounts of dedication (i.e. time and the acceptance of physical, emotional, and moral burdens) in exchange for *great* rewards. One of those rewards is that there is ordinarily significant financial compensation given to medical providers, albeit some work is more highly prized than others (e.g. a physician's salary versus a nurse's). But the most significant reward is thought to be the ability to help people: the privilege to help them recover from, or survive injuries or illnesses to live healthier, happier lives, or to be present for their decline and to give them comfort and care before their ultimate death. Caring for patients is an act that touches upon emotional depths that we may have little access to in other aspects of our lives, as medicine tends to bring out the vulnerability and humanity in all of us.

My focus is heavily on the extreme and unsettling moments that exist in healthcare spaces, and how this negatively affects caregivers, because occupational stress is generally a negatively experienced phenomenon – one that is not always externally driven. In addition to extreme circumstances that arise, there also seems to be an unspoken culture of *extremism* in medicine, around who can handle the most extreme case or situation. Due to systemic constraints, healthcare providers are often put in a position where they must go above and beyond to compensate for any failure of the system to properly care for patients. And because caregivers are often so dedicated to the cause (i.e., to help), I have witnessed how many of them will do just about anything to be the one who 'rescues' the patient. Medical students, residents, and even staff might compete to be the ones who stay to finish the job, who have stayed awake the longest, who clocked the greatest number of hours, or who tackled the most difficult surgery. The individual commitment from providers to meet the challenges medicine presents head-on I find to be extreme, sometimes to the point of forgoing basic needs.

I have a nursing colleague who once told me that "you eventually just lose the sensation of having to pee, and power through it." She reflected on how she was "scrubbed in for a liver transplant for thirteen hours and forgot about everything else." Dr. Rana Awdish, author of the book *In Shock*, echoes this sentiment. She refers to wondering if doctors are somehow different from everyone else, almost superhuman, as "a twelve-hour case meant twelve straight hours in which you did not move from the operating room table...you learned not to drink or eat, you learned not to feel hunger or indulge thirst." (Awdish, 2017). There is almost an insidious internal drive that healthcare providers feel to work harder than they might otherwise consent to in non-healthcare settings. My curiosity lies in wondering how much of this internal dialogue is propaganda driven by outdated medical beliefs, and how much of this behaviour is truly necessary?

Interestingly, from what I have observed in the hospitals that I work in, the desire from caregivers and caretakers to meet both patient and systemic needs have appeared to wane since the Covid-19 pandemic. Staff seem to finally notice that the expectations placed upon them are unreasonable, and far from sustainable. There is still a high degree of self-sacrifice taking place, especially for the sake of the patients. I have witnessed the personal guilt that appears to be driven by the belief that saying "no" (or setting healthy boundaries) means that you let the patient, your coworkers, and yourself down. But there are always more patients to see and there is endless work to do, and never enough care to go around. The punishing effects of having to always do "more with less" are often felt by patients (e.g., those who forgo a water glass for six hours) but are also acutely absorbed by caregivers and caretakers (e.g., those who must struggle to attend to way more patients than is safely recommended).

From my vantage point, there is also a lot of frustration taking place. Consider the neurology patient who is ready to leave the floor and go to the rehabilitation unit, a step towards getting better and being discharged home, but they are not accepted by rehab due to issues with bed capacity. This seemingly simple need – to be discharged to the required healthcare unit (i.e. rehab) – to progress with that patient's treatment, an act that will also make room for patients who may need that neurology bed, can become a daily torment when you encounter the same issue over and over. Having to make quick and decisive choices out of what often seems to be an array of bad options can also take a toll. You either refuse to accept the new patient and keep the neurology patient, or you send the neurology patient to rehab without a spot having been secured, meaning they may be rejected upon their arrival. Neither of these are *acceptable* options, they are also not possible. Patients need a physical place to go, and they need to be cared for by staff. But caregivers are placed in a position where they have to make 'something' happen, which further risks creating 'bad blood' between departments when bad decisions get made.

Such recurring trends can begin to frustrate well-meaning providers who are simply trying to help their patients and promote the flow of services and care in the hospital. The deeply felt "inability" to solve what should be straightforward problems instead becomes constraints that cause anger or apathy, the former being an emotion and the latter being a coping mechanism, both of which appear to be behaviours that are required to survive in these environments. These situations promote reactions that are maladaptive, but adaptive, nonetheless. The root of these problems does reflect the historical ways of doing things. The culture of medicine can breed the impractical and sometimes inhumane demands of the system itself. The constellation of stressors listed above, a grossly incomplete list, creates a fertile breeding ground for much of the physical and psychological unwellness that is found in medical staff, combined with culturally driven choices that can cost caregivers their time, energy, and personal resources, while also subtly and pervasively supporting the idea that it is *okay* to neglect one's own need for care and respect.

The ways in which healthcare providers adapt to and operate within medical culture seem to be predicated by slow shifts in knowledge, belief, custom, and action. A surgeon once said to me, while we were discussing the pervasive issues of burnout, long hours, and terrible working conditions for surgical residents, that "that's what it means to be a physician." There was no sense of lightness in this statement, it was as if to say: that suffering is what it takes, and no one will come to rescue you, you simply must survive or leave the profession. This came from a practitioner who was moulded by the tougher era of medical teaching, a time when mentors would have operated under the strict regime of paternalism. I could tell that they truly believed what they were telling me. They felt that because they had suffered, they expected others to. Their experience made them the surgeon they are today, and therefore, they believed that their students should undergo the same process. The nurses call it "eating their young." Any failure was thought to be the individual's fault. Such short-sighted beliefs and actions can be good for the system in the short term, as caregivers sacrifice everything to keep care delivery going. However, this self-enforced and self-surveilled abuse eventually irreparably harms caregivers, the stress of which may cause them to accidentally harm patients by mistake, or one day, even themselves.

In this chapter, I have purposely drawn our attention to some of the features of intensive care wards, specifically those I have worked in, noting circumstances that affect thoughts, feelings, and behaviour; I described the general features of the ICUs in my province and outlined how care is delivered and organised. Further to this, I have engaged in a discussion around the cultural influences and social habits that shape ICU care and ICU caregivers, as well I listed some of the demands (physical, mental, and emotional) that are placed upon critical care staff, many of which provoke or perpetuate internal stress. The purpose of this chapter was to set the foundation for those external to healthcare environments to appreciate some of the pressures that operate in these spaces, as well as to emphasize to those already familiar with medical spaces what might be affecting them.

The next chapter is dedicated to discussing the ways that medical life can affect an individual's identity (both personal and professional). My focus on identity was brought about during the analysis stage. I noticed how much of the data was self-focused and related to a person's sense of self, their desire for belonging, or to appear a certain way (e.g., professional, composed, and competent). Many of the factors that drive stress in the ICU can be traced back to our ideas about our profession, such as who a doctor or nurse ‘should’ and ‘shouldn’t’ be, as well as the ideas we have about ourselves as people who embody ‘desirable’ or ‘undesirable’ character traits. How we change over time has a lot to do with the medical ‘selves’ that we become, selves that are not built in a day nor can they be dismantled in a day.

Chapter Four

Identity & Integrity

4.1 Liminality

> “Anthropologists describe places, experiences and persons as being *liminal* when they are neither one thing nor another, neither this nor that” - Arthur Frank

In this chapter, I would like us to focus on liminal spaces (or the transitional phases) that caregivers occupy at different times in their lives, to broadly engage with the chronological process of learning to practice medicine (whether it is the study of becoming a doctor, a nurse, a pharmacist, etc.) and the effect this has on a person’s identity. My interest is in the liminal space that rests between a professional's first naïve initiation into the medical field and the seasoned providers' solidified ways of knowing – between these two moments we can observe the drastic changes that take place for caregivers over the years. I want to engage with the moments between uncertainty and assuredness, ostracization and acceptance, as well as in curiosity and determination, since all the liminal phases of one’s career help to define their future professional self. We must keep in mind that one’s identity is never static. Our focus will be on how one’s identity can become enmeshed with the medical life that one lives, and how such an identity can be compromised (for instance when integrity is eroded).

Knowing how individuals perceive themselves (i.e. who they feel they are, or even who they want to become) is critical to understanding the occupational stressors of healthcare providers. This is because the transition from learner to the most responsible healthcare provider (MRHP) marks a transition that will shape a person’s medical practice for years to come, including their beliefs about medicine, and their overall medical armamentarium. While reflecting on becoming a caretaker, I was often inspired to look closely at the concept of a ‘healthcare provider’ more abstractly. I wondered how that core professional (yet deeply personal) identity affected each caregiver’s motives and actions. The process of *becoming* that is special to caregivers, a status predicated on no longer being the person you were prior, but you are not yet the caregiver you will become, tells a tale. Reflecting on this transitory time was a helpful way for me to examine many of the hidden assumptions I had about my work, my ability to cope, and the expectations I had of others. As I muddled through my experiences for this retrospective self-study, I was taken back in time to witness formative moments that had instilled beliefs and behaviours in me.

Arthur Frank, a proponent of narrative research, writes a beautiful foreword to *In Our Hands: On Becoming a Doctor* (2007). This work is a collection of short stories from medical students and residents across Canada, all reflecting upon important and memorable events from their practice. In his foreword, Frank speaks specifically of *liminality*, the space that is thought to exist between the boundary markers of any transitional phase, where individuals have begun an undertaking but have not yet finished it. Frank writes that "physicians in training fascinate because they are partially initiated – no longer lay persons but not yet fully physicians" (Clarke & Nisker, 2007, p. 11-12). Arguably, even after the official celebration for medical students (i.e., the white coat ceremony) which marks their crossing into professional territory, there is still a long road of learning ahead. Residency is no easy task and is fraught with some of the steepest learning curves young physicians will face. Nursing students find themselves in a similar position as they transition towards becoming Registered Nurses (RNs). They are often still in need of much on-the-ground experience to become truly at home in their practice. Medical staff may always be in a state of liminality in that they are lifelong learners, always honing their skills and uncovering new ways of practice and being.

Frank asserts that "liminal transitions are dangerous" and that "risks of pollution increase around liminal persons" (Clarke & Nisker, 2007, p. 11). By "pollution" Frank means that during their training medical students risk becoming insensitive to and bewildered by their more innocent selves. He references a story from *In Our Hands* written by a female medical student (who recounts her dissection of a cadaver) when he says that "she wishes her transformation could go faster" but he is "grateful these stories suspend in time the writer's initiation" (Clarke & Nisker, 2007, p. 12). Frank seems to feel that this student may later reflect differently upon her words then, on how long it took her to fully divorce "the musculoskeletal specimens from their humanity" as she put it (Clarke & Nisker, 2007, p. 12).

Conceivably, the process of becoming a doctor (or any type of healthcare provider) is one of metamorphosis. Our understanding of such a transformation is necessarily reliant upon the fact that change happens over time, but change into what? Frank wants to know if these students will "become richer as human beings or poorer?" (Clarke & Nisker, 2007, p. 12). The question of one's moral identity is at stake here, as Frank indirectly asks: what kind of physicians will they be? He says, "I would most readily trust those future doctors who are most fearful," and by that, I presume he means those who are most aware of the risks involved in learning to practise medicine (Clarke & Nisker, 2007, p. 13). From my perspective, I would not wish for students to be fearful of their medical careers, instead, they should be given opportunities to engage meaningfully with the pollutants of their jobs, to use Frank's analogy, in healthier ways.

Stories (or narratives) can be useful tools for helping us to remember the epistemic positions once held by our past selves. Similar to the stories painted by Frank, and the other authors who collaborated to create *In Our Hands,* this project also relies upon the strengths of narrative to portray the more intimate and difficult-to-describe moments of medicine, i.e., what I have witnessed (or participated in) throughout this study. Frank hints that by writing and telling stories, which he says are arguably also liminal, we can see some truth inherent to the moment as it is retold; yet, that truth is garnered from within the mind of the individual as they reimagine it (Clarke & Nisker, 2007, p. 12). Storytelling can help us to immortalise past pivotal experiences, which can be of service to us (and others) since a person is not capable of knowing what they *do not know* when they first enter the hospital, and it is harder to remember what you have "forgotten since," or have become accustomed to when you are fully indoctrinated into the institution (Clarke & Nisker, 2007, p. 13).

By telling and hearing stories we are simultaneously forced to suspend our current judgements as we carefully look back on the past, yet our current judgements will also be superimposed upon these memories, allowing the differences to become apparent to us. In these multifaceted roles as providers, people, authors, and creators, stories bring outsiders into the hospital, allowing them to peer inside traditionally restricted areas. Stories also expose the more private aspects of ourselves, the parts of our identity that are not always readily evident. Many of the stories I have told in this project reveal parts of me that my colleagues were never aware of. By digging into our personal reactions to caring for patients, dealing with illness or disease, and operating in medical spaces, we divulge our innermost thoughts and feelings, many of which may have been repressed or ignored. Storytellers often share with us their vulnerabilities, self-doubts, and paths taken towards growth – which is therapeutic for the writer. Whereas stories help outsiders to better understand the identities that lie behind what is normally just the stoic and pensive person in a white coat or scrubs.

Dr. Rana Awdish, an intensivist and pulmonologist at Henry Ford Health in Detroit, Michigan, was in the unique position of also becoming a patient in her own care setting. She tells her stories through both writing and painting. In 2008 she found herself suffering from critical illness, and in the pages of her 2017 book *In Shock* – written from the perspective of her ICU bed – she writes:

> "Sitting up, with oxygen on, I began to calm down. It was just a CT scan. I thought of how many scans I had ordered on my patients. How many everything I had ordered? It was shocking how little thought I had given to what it meant to leave the safety of the ICU, to be bumped and jostled and made to lie flat with lungs filled with fluid from heart failure or pus from pneumonia. How pathetically arrogant that I thought only of how clinically useful the images would be, or how necessary the test. I saw the patients leave and I saw them return, and what happened in between was unknown to me. How thoughtless I had been" (2017, p. 87).

Through this story, Dr. Awdish provides us with a more subjective understanding of the relative precarity of transferring critically ill patients, a perspective that comes directly from her own experience of feeling fear and pain while being moved to a CT scanner. In Awdish's case, she was only able to come to this realisation in her ICU bed, the very same bed her patients would have lay in. Rana Awdish's unfortunate experience has given others the benefit of knowing what this is like without having to experience it for themselves. Her narrative contribution, as well as those of many critically ill patients who have similarly shared their knowledge of being cared for in the ICU, all contribute to and grow this shared body of knowledge[36]. But at the end of the day, "a story is neither an unobstructed view of what actually happened nor is it divorced from reality" (Clarke & Nisker, 2007, p. 12). So, if we are looking for evidence about medical life, stories can serve this purpose to some extent, however, they also give us important glimpses into the culture of medicine and the shared ideologies that medical personnel adopt and strive towards.

In *Letter to a Young Female Physician,* Dr. Koven describes the emotional state she found herself in as she watched new medical interns thoughtfully write "self-addressed letters" to themselves, "expressing their hopes and anxieties" before they embarked on their medical careers (2017, p. 1907). She describes how the letters were sealed and expected to be returned to the students after a six-month period had elapsed. These interns were liminally placed, as Dr. Koven writes they were "both letter writer and recipient, both novice and veteran" (2017, p. 1907). As a senior physician and mentor, Dr. Koven relays how she could not help but reflect on her own "abrupt initiation" to medicine, at a time when no one was ever asked to share their perspective on the experience. Now she was "filled with longing" as she desired to tell both her students and her past self "what I wished I'd known" (2017, p. 1907). While the students wrote their letters Dr. Koven wrote one as well, and as you can imagine from the title of her publication, her letter was addressed to – the young female physician.

In her letter, Dr. Koven reflects on her transition in medicine over time, and like the letters written by the students – those stamped and addressed to their future selves – her letter reveals what she thought she once knew, and by contrast, what she *knows now*. In her letter addressed to the young female physician, she recounts having gone through four distinct phases of *knowing* about herself and her profession. In her self-assessment she recounts how through most of her training she was always "looking for reassurance that I was not a fraud" (2017, p. 1908). Her first insight is that "Early on, I believed that displaying medical knowledge – the more obscure the better – would make me worthy" (2017, p. 1908). She would blurt out answers to complex medical questions or spell out correct diagnoses to her peers and superiors looking for reassurance. She felt that this insecurity was good in that it pushed her to study hard, but it was also "superficial" in that "the glow of validation" from being technically knowledgeable, "lasted barely the rest of the day" (2017, p. 1908).

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[36] Another great example of lessons learned from the perspective of the bed of a critically ill patient would be Cheryl Misak's 2005 publication entitled "ICU psychosis and patient autonomy: some thoughts from the inside," where she discusses her "experience of being an ICU patient to make some practical, ethical, and philosophical points about the care of the critically ill. The recurring theme in [her] paper is ICU psychosis." She suggests "that discharged patients ought to be educated about it," "that we must rethink autonomy in light of it," and lastly, "that the self disintegrates in the face of it" (p. 411).

Later in her training, she recounts believing that "competence meant knowing how to do things" (2017, p. 1908). Residents spend an inordinate amount of time being thrown into procedures as novices, having few opportunities to be exposed to them, making perfecting them quite difficult. Dr. Koven uses the example of inserting a central line into a patient, a skill that Atul Gawande elegantly paints a picture of in his book *Complications: A Surgeon's Notes on an Imperfect Science* (2002). The chief resident asks Gawande to insert a central line (or a central venous catheter which is inserted into a large vein close to the heart to administer fluids, drugs, or for dialysis, etc.), having never done one himself. He had only watched others insert them twice before (2002, p. 11-12). This is a procedure I would often watch the residents and doctors complete in our ICU. Gawande says, "Mine were not experienced hands… and the disasters I knew about weighed on my mind" (2002, p. 12). He explains how horrible the conditions were, he had been up all night, and the patient was morbidly obese and could not tolerate lying flat, but he "absolutely needed a central line" (Gawande, 2002, p. 20). He recounts how he "made a rough guess as to where the right spot was, numbed it with lidocaine, then pushed the big needle in…. I *was in*" (Gawande, 2002, p. 21). Dr. Koven, with a sense of pseudo-assuredness, remembers that she felt she could escape the looming sense of fraudulence that haunted her through perfecting procedures like this one, and says "I could endoscope my way to self-confidence" (2017, p. 1908).

A few years into her practice she says, "I was [now] sure that being a good doctor meant curing people" (2017, p. 1908). This sentiment is arguably what the entire structure of medical science is all about, and why people go into medicine/medical sciences to begin with – the hope of finding a cure. However, as many seasoned providers are aware, and Dr. Koven later learns, she says "Even after I tried my best, people got sick and died anyways" (2017, p. 1908). Disease, as well as the patient bodies it disrupts, can be highly unpredictable. Medical providers are also subject to taking bad outcomes personally, which is sometimes warranted, but most times the factors involved in causing patient harm or death are many, sometimes are even untraceable. As the poetically named book *To Err Is Human: Building a Safer Health System* (2000) demonstrates, human error is only one part of the equation, despite the percentage of preventable errors being quite high each year (p. 1). Although Dr. Koven's sense of imposter syndrome is not unique to her alone, her story points to the many parts of her career where she felt fraudulent, incapable, or self-doubting. [37]

Dr. Koven finally turns to her current self, now being late in her career she says, "I understand that I've been neither so weak nor so powerful" (2017, p. 1908). In this newfound epistemic position,

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[37] Psychology Today defines imposter syndrome as "People who struggle with imposter syndrome believe that they are undeserving of their achievements and the high esteem in which they are, in fact, generally held. They feel that they aren't as competent or intelligent as others might think—and that soon enough, people will discover the truth about them. Those with imposter syndrome—which is not an official diagnosis—are often well accomplished; they may hold high office or have numerous academic degrees" (2024).

she says she should have "spent less time worrying about being a fraud" and "more time appreciating… some of the things [her] patients appreciate most" about her, such as her jokes and her hugs (2017, p. 1909). She directs future physicians (especially young female ones) to doubt themselves less, to embrace humility, and to realise that a "sense of purpose" in medicine will be of greater value than worrying about one's potential failure; she says, "your humanity will serve your patients better" (2017, p. 1909). Dr. Koven's self-analysis reveals how her confidence grew over time, and how her expectations went from being somewhat harsh and unrealistic to being more tempered and gentler, especially towards herself – an important feature of well-being.

4.2 Medical Identity

A healthcare provider's idea of their professional identity can significantly impact their well-being in the workplace. Professional identity encompasses how individuals perceive themselves in their role, their values, and their sense of belonging to their professional community. Matthews, Bialocerkowski, and Molineux (2019) say that "professional identity is defined as 'the attitudes, values, knowledge, beliefs and skills shared with others within a professional group'" and that "the development of professional identity has been noted as a continuous process that is influenced by several factors including experiences in practice and professional socialisation" (p. 1). Delvin, Braithwaite & Camargo Plazas (2018) also emphasize that "jurisdiction is a central concept in the theory and includes the social and cultural structures that outline a profession. The cultural aspect refers to the knowledge and skills that define the profession while the social structure of the jurisdiction refers to claims made in public, legal and workplace arenas" (p. 111).

As we witnessed in Dr. Koven's letter, her beliefs about her professional role deeply affected her personal experience and feelings, depending on whether she felt confident and secure in her role, or if she was uncertain, afraid, or insecure. A caregiver's professional identity can influence their well-being if that caregiver's sense of self, their sense of worth, their sense of values and beliefs, and their sense of purpose at work (especially care work, which is a profoundly meaningful part of human existence), can be deeply tied to their personal identity and thus affect it. One's professional identity also runs up against a person's sense of personal identity outside of the workplace, a factor that must be accounted for. A major struggle that I have witnessed throughout my years in hospital has been making room for personal values and personal connection in a system that is still focused upon "Demands for efficiencies, shortened lengths of hospital stays, and increased standardization" all of which "have shifted the provision of care to protocol, guideline and algorithm-driven approaches at the expense of reflective inquiry and patient-centeredness" (Dagnone, et al., 2020, p. e97).

People also change over time. Individuals are continually rediscovering themselves and have countless opportunities in life to shift and mould their being as they so choose, or they do so without much awareness, with limitations of course. This reminds me of the saying, "people never change." In becoming *medical personnel* individuals must reconcile their own personal identity with their newly formed professional identity. Matsui and colleagues argue that "individuals enter the process of socialisation in medicine with their own personal identities" (2019, p. 1) which I feel also includes our epistemic selves (the body of collective beliefs, thoughts, and knowledge a person has accrued). Shared expectations around "who physicians should be" or "what a good nurse looks like" help to shape the cultural understanding of what such a professional identity entails, a transformation that will require "the integration of personal values, morals and other attributes, such as gender, race, personal characteristics, religion and culture" to amalgamate, forming what appears to be one kind (Matsui, 2019, p. 1). In this way, personal and professional identities are ever evolving in parallel.

Personal identity is generally the question of who or what we are, and therefore, it is a subject that is both contingent and temporal. It is generally thought to be related to "properties to which we feel a special sense of attachment or ownership," or those aspects of ourselves that we feel define us in relationship to (or distinguish us from) others (Olson, 2002). Since it is unclear when or how a person is or becomes themselves, the idea of change throughout time is what makes identity very difficult to define. The properties of ourselves that we might point at to define our identity are always changing, so it becomes highly difficult to understand the continuity of an individual item or person (Olson, 2002). The story of the *Ship of Theseus* illustrates this point very well, it is a thought experiment designed specifically to grapple with the problems central to identity. In short, the ship in question had been assigned the identity of being the "Ship of Theseus" after the mythical Athenian hero (Theseus) who owned it, and it was said to be made entirely of wood. Over years of the ship sitting in the harbour in Athens it required maintenance, so each year the old decaying planks of wood would be replaced with new ones until the original ship contained none of the original parts. At this point, the question of the ship's identity was: is this ship still the Ship of Theseus (Lowe, 2002)?

Ideas surrounding the notion of *identity* have attracted much philosophical interest over the years and have been the topic of extensive debate. Work has also been done to analyse the criteria needed to determine identity, whether identity can be contingent or vague, how it persists throughout time, or even whether it can remain coherent across possible worlds (Noonan, 2018). Despite the large body of work dedicated to this topic, i.e. attempts to clarify the metaphysical nature of identity as well as provide logical proofs for identity, and even though questions related to identity are indeed interesting, I will have to put aside some of the classic problems with identity for now (such as how identity can persist over time) since this is not the focus of this project. It is fine to have the paradoxical nature of identity rest in the background, since we can assume for now that people change throughout time.

It is not important for my argument whether we can accurately and successfully point to one particular identity as being static at any given moment. Instead, I am more interested in the social changes that ebb and flow for people who associate their own personality or character with the professional role of being a healthcare provider (e.g. physician, nurse, etc.). The entanglement between personhood and occupation is what I find of interest here because it is a phenomenon that has been subjectively observed. Researchers Vivekananda-Schmidt, et al. concluded that what they have called "professional self-identity" (PSI) (which is the "degree to which an individual identifies with his or her professional group") is formed by both the learner's self-perception and their perception of their professional role, neither of which are static (2015, p. 1). Such an overlap is aptly expressed by two questions that Vivekananda-Schmidt and colleagues drew from the data of the 17 student doctors and dentists they interviewed from the University of Sheffield, which include: "What is it that I need to become?' [with reference to the future professional role] and 'Am I capable of becoming what I need to be?' [with reference to self] (2015, p. 7). These questions point to the perceived relationship between one's capabilities as an individual, be it grit and determination, or giftedness and natural abilities, and one's future self as a proficient or capable caregiver.

Lewin et al. (2019) argue that "the formation of a physician's professional identity is a dynamic process shaped by and intertwined with the development of that person's larger adult identity" (p. 1299). These authors use Robert Kegan's model of adult development with which to ground their claims, whereby individuals are thought to use different lenses with which to view the world around them, ultimately shaping their reasoning and resulting actions. The various lenses include instrumental (or one's desires or needs), socialised (which involves the expectations of important groups), self-authoring (encompassing one's value system), and self-transforming (or evaluating different perspectives, even if they are conflicting) (2019, p. 1300). Rees and Monrouxe (2018) similarly argue that our professional identities are socially formed as they are "Influenced by the relationships we have and by institutional structures and cultures…our identities are shaped and reshaped every day as we contemplate our social worlds." (p. 202).

Such a collaborative sense of identity is shaped by many experiences, mentors, opportunities, and internalizations. Delia Gavrus (2011) writes that "scholars have shown that medical identity is negotiated through various cultural practices, such as esthetic choices, public displays and iconography, and rhetoric—the practice of using argument and language, orally and in writing, toward a certain persuasive end" (p. 60). You can consider a professional identity to be somewhat coherent and related to the ethos of a particular group, e.g. neurosurgeons are too quick to take a radical approach and cut patients, scalpel always in hand, whereas neurologists take a gentler therapeutic and cautious approach in treating non-invasively. Both examples are exaggerated and not necessarily charitable assessments of these two groups, but they could be considered social constructs of a particular professional identity (Gavrus, 2011).

The continual process of having to shift between selves, e.g., being a general surgeon in the operating room during the day and being a loving mother to four-year-old twins is not something that is hung up on the wall like her white coat at the end of a long day. Like the difficulty of understanding our identity throughout time, the professional identity of a medical professional is equally bound up with the fluid nature inherent to change. This is perhaps why caregivers are often unable to shake off the difficult experiences of their day to resume the normalcy of being just a parent or spouse, etc. Vivekananda-Schmidt, et al. echo this sentiment saying, "If we do not carefully consider these issues, we are in danger of giving our future healthcare professionals 'surface professionalism' which 'sidesteps issues of identity and treats professionalism as something physicians can put on and take off like one's stethoscope'" (2015, p. 7).

Arthur Frank's concern, if we recall, was that "risks of pollution increase around liminal persons" (Clarke & Nisker, 2007, p. 11). Identity is a core concept for how healthcare providers associate their character and self with the role they assume in the workplace. Many occupations require a degree of the person's self to be invested in both the workplace and the work itself, however, the adoption of a medical identity seems to blur the line between personal and professional identity more severely than other occupations. For this reason, when faced with occupational stress and the harmful consequences that follow from symptoms such as depersonalisation, the individual not only threatens their work identity but also their innermost self.

> I remember when I used to want to be a physician. I wanted so badly to wear the white coat, to have a stethoscope around my neck (or to be able to say sphygmomanometer), to wear scrubs everyday, and to be able to wear what we called a 'moon suit' in surgery. I romanticised medicine as I poured over books like *Bloodletting and Miraculous Cures*, *When Breath Becomes Air*, or *Being Mortal*. I also watched television shows like Scrubs, Grey's Anatomy, House, and Medical Examiner. I loved it when people would talk about their medical problems, and if someone needed help, I was excited to try out my medical knowledge. I recall cleaning, sterilizing, and carefully wrapping my partners hand after a woodworking incident. I also loved volunteering to drive people to the emergency room, which I did for my partners mother after she almost cut her thumb off using a kitchen tool. I was happy to wait the six hours in ED late at night, it made me happy as I felt I was helping and part of that world for a moment. I studied for the MCAT, owned anatomy books that I would examine carefully, and I just couldn't wait to apply for medical school. This was until I was faced with the reality of medical life in my job. After a few years, it was impossible to ignore the burdens caregivers were saddled with, such as having to tell a family that their loved one just died, to stick your hand into a patient's distended abdomen, or waking up at 4 am to round on your patients before heading to the operating room for a full day of surgery – typically spent without food and water. These factors were not necessarily deal breakers for me, but these experiences did provide me with a very necessary reality check, which was the knowledge that choosing this life

> would be a choice that would harm my very being. Not only would I be tired and cranky all the time, and my body would be unbalanced and overtaxed, but I would also be morally damaged, mentally strained, and consistently uncertain. I was not sure I was willing to put myself through all of that, but I knew my passion was medicine; so, I steered myself in the direction of medical ethics.

It is important to note that the challenges a person must face by virtue of their chosen professional identity, such as exposure to stress, tragedy, conflicts with organisational values or ethical dilemmas, and the many more situations I have already mentioned, are evidence that a stressful or toxic workplace will negatively impact a person's wellbeing. Therefore, fostering a positive professional identity through mentorship, supportive work environments, and opportunities for professional growth is crucial for the overall well-being of healthcare providers.

The point I want to make is that through the slow erosion of one's professional values and identity comes the erosion of the person's sense of self in the workplace, which can also affect that person inside since many of us bring our personal values and principles to the workplace. The slow process of erosion happens due to consistent exposure to trauma (so not having sanctuary where/when it is needed), exposure to stress (where staff do not have ways/opportunities to relieve their stress), and lastly, exposure to moral distress and injury (whereby staff are made to compromise their values time and time again). Integrity, or a caregiver's sense of wholeness and well-being (where their values remain intact, are respected, and nurtured) is broken by repeated exposure to negative events and situations where caregivers are asked to make peace with being forced to break moral rules, harm patients, and accept harm themselves. This aspect of caregiving is not sustainable.

For many caregivers, their profession is considered a "calling," or a deeply meaningful practice, so meaningful that it would satisfy these individuals for an entire lifetime. Some people get into medicine without really knowing the score, in terms of the essentially identity-altering time and energy that is required to do it and do it *well*. Some seem to find medicine to be a perfectly good career, but they do not consider it to be more special than any other job they might find themselves in. Others seem to feel it in their heart and souls and are beyond thrilled by every uncovering of the body and every possible treatment of patients. The journey through medicine is also not linear and can take many forms. Many healthcare providers are living a second life having gone back to medical school later having had other careers, some live simultaneous lives and are businessmen as well as anesthesiologists, and others are lifers: they may have had parents who were doctors, or they simply entered the hospital at a very young age and have never left.

A surgeon once peered over my shoulder as I leafed through an MCAT (medical college admission test) textbook in the operating rooms one morning, and he said with excitement "Are you hoping to become a doctor one day?" I said, "I am daunted by this exam, but maybe," to which he replied, “I love my job very much, I can't believe they pay me to do this, I am so excited to come to work every single day.” He was a lifer, he loved medicine, his patients, and his workplace and appeared to be both self-actualized in his choosing of this career and genuinely happy outside of it. How deeply ingrained his own personal identity was with his role as a surgeon, I do not know, but the match seemed to be made in heaven. This provider seemed to enter the field of healthcare because they strongly identified with what can be considered both the medical sciences and the healing arts, they felt a calling to help patients get better from illness, loved solving the puzzle of disease pathology, and they felt safely at home in the hospital environment.

At the end of the day, job satisfaction is one important aspect of medical identity, and job-person fit is necessary, as Maslach argued (2012, p. 297). A person must have a strong and positive professional identity to obtain such job satisfaction, by feeling a purpose, having pride in what one does, and thus getting fulfillment out of one’s role. These factors also affect mental and emotional well-being. Having a strong sense of purpose can help providers tackle challenges, and have a better sense of their values, boundaries, coping strategies, and knowledge of their limits. A person's ability to trust themselves and to develop trust and respect with others helps with a sense of professional belonging and allows caregivers to connect with their professional community in healthy ways. Lastly, a well-defined sense of professional and personal identity can help one navigate moral dilemmas, given that they have a good sense of what professional standards they wish to uphold, what personal ethical principles they value, and how they communicate this with their patients and colleagues. Overall, a robust sense of identity helps maintain resilience and for coping with the physical, emotional, and psychological stressors of the job.

Furthermore, if we look back to our previous discussion on “awareness” in Chapter 3, it is easy to imagine how awareness is a key part of becoming familiar with our identity. To act in accordance with what one believes to be correct, good, virtuous, or even warranted, a person must be aware of how they *are* (i.e., how they are acting and behaving). This requires self-observation, observing one’s thoughts, feelings, and actions, as well as observing how one acts with others or when alone. If a person’s beliefs are completely misaligned with the way they are acting, then there is a discrepancy which must be sorted out if a person wants to act on their true feelings. The benefit of developing a skill like self-awareness allows one to deeply understand what is driving them, what their goals are, why they feel certain ways, and why they react to certain situations. Once a person becomes aware of how they are, what they think, and what they believe, they are in a much better position to align those thoughts, beliefs, and actions with the moral values they seek to uphold or want to promote and share with others.

4.3 Identity as a Mechanism for Social Belonging

Another feature of identity, and what I have noticed to be salient in my autoethnographic data, is how our beliefs about ourselves also connect to our titles within the hierarchy of care, beliefs that can readily shape our relationships with others in the workplace. I often felt stuck in my limited position as a ward or research clerk, and even though I had master's level ethics training, I was not taken seriously in medical spaces for a very long time. I would also hear other people express sentiments in the workplace that directly reflected their perceptions of their work status and further seemed to reflect on their beliefs about their personal capabilities, e.g., "I can't believe that made me sad, I wasn't even taking care of the patient, I'm just the unit aide," or "How did I get the central line on the first try, it's only my second week on ICU as a resident!?"

Identity and identification are ways that we engage with and present ourselves to the world, and this means our titles matter. Medical identity is tightly wrapped up in the institutional framework that thrives on prestige, words like "life savers," "heroes," or even "Gods." However, as discussed earlier, not all medical roles are valued as highly. A person's work identity is also a label, a dividing line, a hierarchical placement, and arguably a caste. The housekeeper is below the unit aide, the unit aide is below the nurse, the nurse is below the physician, and the family physician is below the neurosurgeon, this is the way people seemed to think about rankings from my own experiences. These labels can affect how we are treated in the workplace, even if they shouldn't. Whenever I would act in a way that either propelled me past my seeming "place in the world" (i.e., my status as *only a clerk*) I would feel uncomfortable as if I was doing something illegal, similarly, if I shared an opinion on something I was capable of weighing in on, but was beyond my scope, a superior staff member could choose to remind me of my place.

> I attended ICU rounds for a month when I first started in ICU to learn about the unit and to help my understanding of my role in collecting patient data. Everyone would huddle around the first patient's bedside at 9 am to listen to the various caregiver's reports. Some cases were major learning experiences, and I would hang on to every word the intensivist said, whereas others were routine and less interesting, meaning my attention might wander off. Rounds lasted until noon when you had to stand for three hours straight and listen attentively. Often, I had questions, but I always reserved them for quiet moments at the end – in between each bedside – to ensure that the residents had gotten everything they needed from the staff physician. One day I asked, "So, why is this girl's liver failing, is it because she has rhabdomyolysis, or…" just then I was interrupted by the resident asking the physician if they had "Hit the gym up recently?" The physician looked away from me, even though they heard

> my question, and began to engage in a conversation about working out as if I wasn't even there. I decided to just slowly wander off to the next bedside because I felt embarrassed and ignored. I also thought, my question wasn't as important, because I am not a resident.

These divisions come out in the workplace not only through name tags, pay cheques, or uniforms; they also emerge in the form of social and cultural pressures. I have witnessed how the nurse is easily interrupted by the doctor, or the nurse's opinion is ignored since it is not viewed as highly as the expert physician's opinion. The housekeeper is spoken to sternly to impress upon them their place, as someone who merely cleans, and is treated inhumanely under the guise that they do not contribute to saving lives, even though they are critical to this process. As a unit clerk, I often saw the true colours of people since my position was one of the lowest in rank. This meant that people were not afraid to be abusive towards me and they often didn't seem to care what I thought. I was able to see different sides of people who were surely thought of as pleasant upstanding professionals in their executive meetings. However, once it was after hours and it was just me and them, the rules seemed to go out the window. This was because my humanity was separated from my role as a lowly worker. My value was not inherent to my very being, instead, I was cast into my role as someone undeserving of patience, respect, or consideration.

O'Shea, Boaz, & Chambers (2019) explain how "Stratification constitutes a hierarchy which distinguishes between individuals on the basis of power to influence. Variations in power status within healthcare structures are widely documented, with reference to paid professionals occupying more dominant positions" (p. 8). The effects of *social caste* (as described by Isabel Wilkerson in her 2020 book, *The Origins of Our Discontents*), is an invisible structure that affects everything we do, and what we are *allowed* to do. Caste is the name for systematically fixing groups of people based on their hereditary history, or their social value, often referring to India's caste system and Hindu society, e.g., "At the top of the hierarchy were the Brahmins who were mainly teachers and intellectuals... Then came the Kshatriyas, or the warriors and rulers... The third slot went to the Vaishyas or the traders... At the bottom of the heap were the Shudras, who came from Brahma's feet and did all the menial jobs. Outside of this Hindu caste system were the Achhoots – the Dalits or the untouchables" (BBC, 2019). The last group is not regarded as being worthy of being part of the caste system itself, they are viewed as sitting outside of it. Wilkerson says that:

> "Caste is structure. Caste is ranking. Caste is the boundaries that reinforce the fixed assignments based upon what people look like [*or in our case, how they behave*]. Caste is a living, breathing entity. It is like a corporation that seeks to sustain itself at any costs... Caste is the granting or withholding of respect, status, honor, attention, privileges, resources, benefit of the doubt, and human kindness to someone on the basis of their perceived rank or standing in the hierarchy... Caste is insidious and therefore,

> powerful because it is not hatred, it is not necessarily personal. It is the worn grooves of comforting routines and unthinking expectations, patterns of a social order that have been in place for so long that it looks like the natural order of things" (2020, p. 70).

Medicine has its own *social caste* system, one that is known and recognized but rarely talked about openly in hospital settings, or 'on the floors', as we say. Historical facts will point to the role of the nurse as being less prized than the role of the physician, and gender stereotypes have further affected women's ability to enter the medical profession and overcome the hierarchical social rules (Weiner, 2020). These categorisations of knowledge, ability, and identity perpetuate the mistreatment of those sitting below each 'caste' or ranking, as those in higher castes or rankings are presumed to be worthy of better treatment. Even with expert knowledge (that comes with a medical degree) a person does not automatically always have good intentions (e.g., Philip Markoff was a medical student at Boston University before he was arrested for shooting a woman and killing her), meaning, people at the top of the hierarchy are just as capable of harm and mistreatment. Being a knowledge holder or being powerful is not synonymous with care or integrity.

> "Themes of power, dominance, and hierarchy are prevalent analytical terms in sociological studies of health care, and Foucault's concepts around power and knowledge can be applied to traditional views of the doctor-patient interactions. In historical contexts, Foucault theorized power of knowledge as embedded in dominant discourses and systems and viewed critiques of knowledge and truths as both pervasive and dominant. Under such an analysis of power and hierarchy, the medical profession maintained the upper hand by having greater knowledge, expertise, prestige, organizational support, and stability. The patient/public with historically less power such as women, minority groups, and the poor would have been more vulnerable playing "second fiddle" to medical authority and lacked the resources to question medical decisions or challenge prescribed care (Foucault, 2003, as cited in O'Shea, Boaz, & Chambers, 2019, p. 2).

A person's worth is inherent to the nature of their very being, it is not defined by their occupational role or status. The knowledge of, and ability to act in ethical ways or to have compassion, empathy, or emotional intelligence are completely different skill sets than knowing how to fix bone or graft skin. Yet, in stratified systems of power, the most valued knowledge holders (and caregivers) are often the most educated persons, who also become the decision makers, are invited to decision-making tables, and are given both the opportunity to speak and the respect of being heard. Without these opportunities, it can be very difficult to instil change, as one is unable to escape their professionally designated identity. Housekeepers and cleaners were praised during the Covid-19 pandemic, as people realised how vital sanitation practices and workers are; however, this brief recognition does not touch the cultural beliefs of those who have been brought up to believe that the physician is indeed more praiseworthy and more respected than anyone who chooses a sanitation job.

In summary, it is important to note that the expectations we place on ourselves, and on others, are connected to our professional identities, which have 'baked into them' our private perceptions about worth, status, titles, and roles. I have provided many examples in this project to demonstrate how power, influence, and authority both subtly and overtly affect the interactions between caregivers, caretakers, and patients. You might think back to the surgeon who swore at me and hung up the phone, the awkward debriefing where only a few people spoke up, or the resident who refused to speak to their plastic surgery patient even though she had been waiting for hours. All of these situations were examples of how a more powerful person can influence others. I have always known (through my cultural immersion in Western culture) that the title of 'doctor' alone was enough to create a simple power imbalance, however, after pouring through my data, it became clearer to me that if a person acted as though they were without a doubt *better* than others, this was not just a reflection of their professional identity, this was evidence of their personal identity shining through.

The most important points are to recognize that (1) the experiences we have in our professional life will be, to a significant degree, shaped by the social norms of the profession we enter; (2) our professional identities will also be moulded by the particular sub-cultures that we exist in; (3) our professional identity can strongly affect our personal identity, and for that reason, it can affect our wellbeing; and lastly, (4) our beliefs about worth and social caste (which are often embedded into our personal identities) are problematic for the humane treatment of all caregivers.

Chapter Five

Emotional Labour

Another concept that exists in the broader literature, and a theme that was drawn specifically out of my autoethnographic data, is that of emotional work, management, or labour. In reviewing my narrative data and the general themes that I had organised for myself it became clear that a significant degree of the work I was doing in both the operating rooms and the ICU was emotionally *laborious*. In broad strokes, I found my jobs to be stressful, exhausting, draining, complex, and demanding. When I looked deeper into the various tasks I would complete at work, I asked myself, "Why is this depleting me?" I noticed that a lot of my time was spent engaging in emotional management or trying to control my feelings. I often engaged in behaviours that were carefully designed to help me present as a composed, thoughtful, intelligent, and knowledgeable person, as well as an overall competent worker. I did not yet have a word for this experience (such as 'emotional management', which will be defined and discussed in this section); instead, I could only describe how whenever I felt emotional distress or confusion, I would try to solve these situations by manipulating situations, people, or myself.

In medicine, there is an unspoken drive towards rationality and a calm demeanour, which is usually an effort to present oneself as unaffected by medical events or even *imperturbable* to them, according to William Osler (Jones, 2019, p. 2901). In one of his most famous essays which "was first delivered to newly minted doctors in 1889 as a valedictory address at the Pennsylvania School of Medicine" (Sokol, 2007, p. 1049) he urges medical students to consider the adoption of:

> "Imperturbability ... [which] is the quality which is most appreciated by the laity though often misunderstood by them; and the physician who has the misfortune to be without it, who betrays indecision and worry, and who shows that he is flustered and flurried in ordinary emergencies, loses rapidly the confidence of his patients. Keen sensibility is doubtless a virtue of high order when it does not interfere with steadiness of hand or coolness of nerve; but for the practitioner in his working-day world, a callousness which thinks only of the good to be affected, and goes ahead regardless of smaller considerations, is the preferable quality" — William Osler, Aequanimitas, 1889.

One can easily imagine how the root of this practice was probably born out of the common social intuition that a flustered or hysterical physician appears unknowledgeable, and that their outburst must be a sign that they are inexperienced and have no clue what they are doing. The logic behind Osler's original sentiment is reasonable, however, it paints a very black-and-white picture of medical situations – that caregivers are either imperturbable or incompetent. There are many dispositions between these two extremes. Additionally, the imperturbable physician may seem calm and competent, but there is a morally significant difference between the natural poise of a seasoned caregiver who presents this way because they do know exactly what they are doing, versus the stoic caregiver who is frightened and uncertain of themselves, but they refuse to voice their concerns or reveal their uncertainty due to a further fear that they will be judged.

This deeply embedded fear appears to cause caregivers to either numb or hide their feelings, an unhealthy type of emotional *management*. "The ideology of affective *neutrality* is strong in medicine; yet no courses in the medical curriculum deal directly with emotion management" (Hochschild, 1983, emphasis added). In 1989, Smith and Kleinman noted that "two years of participant observation in a medical school revealed that discussion of the student's feelings is taboo" and that "their development toward emotional neutrality remains part of the hidden curriculum" (p. 57).[38] Today, this problem remains, as I still see medical learners being scolded harshly, made to feel embarrassed, or outright abused by their mentors. Further to this, I have seen similar mistreatment between seasoned physicians (those who are tenured staff). Even though "contemporary bioethics and medical literature highlights the positive effects of empathy for patient care… very little attention has been given to the impact of the requirement for empathy on the physicians themselves," meaning caregivers must continue "to be empathetic towards their patients, but the effect of this requirement on their emotional wellbeing is rarely acknowledged" (Kerasidou & Horn, 2016, p. 1).

Delivering medical care can provoke emotion in many ways, e.g., in response to witnessing the mistreatment of patients or bad behaviour, experiencing feelings that arise from intimate patient contact (conducting a pap smear), or that simply arise as a result of the learning process itself (e.g., academic demands, competency assessments, etc.). Toufan, Omid, & Haghani (2023) write that, "Feelings are constantly associated with learning and affect information processing. They are influenced by educational situations experienced by students in classrooms and clinical settings. Although the learning processes and academic emotions are interrelated, it is shown that what students feel is not just about academic feelings" (p. 3). Their evidence demonstrates how "research on medical culture reveals that bullying and abusing students is common" and how "a survey of undergraduate medical students in New Zealand and the USA found that humiliation, along with verbal harassment, was the most common form of abuse, a behaviour that could affect learning" (p. 3). And while the

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[38] The hidden curriculum (HC) refers to a "phenomenon in medical education was first documented by Hafferty and Franks who observed that most of the critical determinants of physician identity do not operate within the formal curriculum but in a more subtle and less officially recognized HC context. The HC includes intended and unintended implicit messages about values, norms, and attitudes that medical learners (medical students and residents) and practising physicians (hereafter called faculty) infer from their interaction with role models, as well as from group dynamics, processes, culture, policies, structures, and systems" (Schultz, et al., 2023, p. 2).

students emphasised how "the long-term effects of embarrassment can be positive; the emotional distress reduces their overall value as learning events" (p. 3).

Presumably, no one wants their doctor to "fake it 'til they make it," contrarily, many patients *want* their doctors to show more emotion, particularly caring emotions like empathy and compassion.[39] In this chapter, I will further bring to life the theme of 'emotional labour' as it connects both to the literature and my own experiences in the hospital. The importance of this theme is to fully outline the scope of harm that can come to individuals who are made to ignore their emotions for long periods, and how this affects clinical practice at the bedside.

5.1 Quietly Emotional Caregivers

Medical practice is rife with circumstances and stimuli apt to provoke a wide range of human emotions, existential wonder, moral crises, and traumatisation – the greatest disservice medical education, residency programs, and systemic cultural reinforcements have done for medical personnel is to disempower their feelings and silence their emotions. The long-standing ritual of ignoring feelings, repressing difficult emotions, or inhibiting the natural flow of tears in front of patients (because it is thought to be unprofessional or detrimental to the patient or their family) is ultimately harmful to caregivers. Emotional guilt, shame, or repression are fundamental contributors to job stress (or what I have referred to as occupational stress) and dissatisfaction in one's career. These emotional management tactics only function to stave off emotion for a short while, but these behaviours will eventually lead to anger, resentment, and estrangement due to the blocking of a person's natural ability to express themselves. This is especially true for caregivers in the ICU because (1) they rarely have people to talk to about their work outside of the workplace; (2) if they fail to find ways to openly discuss their stressful experiences at work, they tend to move on and never revisit these feelings again.

This does not mean that a caregiver should openly cry at the bedside, share their feelings in an unsafe environment, or always refrain from holding back feelings that they would prefer to deal with in private; instead, caregivers should follow their natural instincts and determine what feels best for them. They should still examine the coping strategies they use in order to determine how healthy these strategies are, especially if used long term, but there should be no 'feeling rules' beyond personal comfort and choice. My argument is fundamentally related to addressing the subtle social prohibition of emotional displays, and the void of emotional support systems that could be in place to reduce occupational stress and related disorders. We must seek to bring emotion back into medicine and assure caregivers that how they feel is valid, normal, and even productive.

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[39] Douglas Mann (2022) describes "fake it till you make it" as referring "to the idea of projecting self-confidence in order to convince yourself that you can attain a goal that you feel as though you do not yet have the skills to achieve" (p. 99).

Emotions are important because they give us information about ourselves, others, and the world around us; they are signs from the physical body and from our subconscious mind to our conscious self – alerting us that we need to pay attention to something. "Emotion is often defined as a complex feeling which results in physical and psychological changes affecting thought and behaviour. Emotions include feeling, thought, nervous system activation, physiological changes, and behavioural changes such as facial expressions" (Drigas & Papoutsi, 2018, p. 45). Humans have a wide range of emotions they can feel and express, but not everyone is aware of their emotions, and some may have trouble reading the emotions of others. Typically, more basic emotional reactions involve feeling happy and smiling, feeling angry and frowning, feeling sad and crying, or feeling shocked or surprise and gasping. However, there are many more feelings than this which are more complex and may be harder to identify or name, such as feelings of powerlessness, victimisation, astonishment, disillusionment, and shame.

Emotions are important for the survival of humans since emotional cues help reduce harm to oneself in terms of avoiding threats or listening to one's body and the environment. Emotions are also a key feature of properly building and maintaining relationships. If someone is unaware of their own emotional sensations, either in their body or what's happening in their hearts and minds, they are more likely to suffer adverse effects from failing to recognize their own emotions (which may continue to be felt, even increase in severity, from being left unaddressed). This can lead to negative patterns of operating in the world, where an individual will lack an important degree of self-knowledge tied to their emotional reactions or triggers, leading them to have a reduced sense of understanding one's own needs (possibly neglecting the self), and potentially contributing to developing negative or poor conceptions of the self and/or others due to emotional detachment or ignorance. These features of emotional unawareness can diminish one's ability to problem solve or coherently and confidently make decisions, which can lead to general suffering.

From my own extensive experience and given the many observations I have had of medical learners and veteran staff, it often seems as though medical education and residency training have built emotional denial into the hidden curriculum, i.e. through tacit and unintentional teachings, where the perceived virtues of stoicism, silence, and repression are continually mentored and upheld within the general social and moral community of healthcare. Research has shown that many medical interns[40] "generally considered crying in the work setting more as a sign of weakness and strongly felt that a crying physician is not fit for the job" (Janssens, Sweerts, & Vingerhoets, 2019, p. 412). What makes them feel this way? McKegney (1989) refers to medical education as "a neglectful and abusive family

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[40] The literature in this section focuses heavily on physicians and medical learners as they experience mistreatment. This is because a copious amount of data has been collected on these individuals. However, in my tacit experience working in a hospital, these experiences are not restricted to physicians alone and can be felt by any member of the team, including clerks, unit aides, nurses, pharmacists, dieticians, and physiotherapists, to name only a few.

system," one that could be "characterised by their unrealistic expectations, denial, indirect communication patterns, rigidity, and isolation" (p. 452).

Students and residents learn to practise medicine under a series of supervising physicians, as do almost all caregivers who are learning to practice in the hospital, such as younger nurses learning from more senior nurses, many of whom may have experienced emotional abuse during their training. McKegney says that "like parents who raise their children as they were raised, each generation teaches as they were taught, and the patterns are loyally perpetuated" (1989, p. 452). Singh & Singh (2018) report how "despite promising efforts, student mistreatment remains an ongoing challenge in medical education, with published studies continuing to report high rates (80%–90%). Trainees, medical students, and female staff and colleagues are identified as the most likely targets" (p. 145).

In another example, a 2022 article in *Science* entitled "Academic mentors wield great power – We need to feel safe talking about abuses" which was written by an emergency medicine physician at Harvard Medical School, tells a story of abuse. She writes:

> "I was a Black third-year medical student, fresh-faced and longing for guidance. The faculty member, a physician, was in his 60s, tall, white, and commanding. "How can we treat the patient's infection, Adaira?" he boomed as our team made rounds on the ward. I listed answers, cashing in the hours spent with my nose buried in books. Our footsteps kept a brisk pace on the linoleum floors as he turned and gave me a slight nod. It was an expected brush of acknowledgement—no smile, no prolonged attention. Back at the workstation, I volunteered that I was interested in infectious disease. He offered to walk me through a related clinical research project. As a young Black woman student, I'd heard "I'm sorry, I'm busy" from potential mentors all too often. It would have been foolish to decline. I hoped this project would make me a published author, a coveted accomplishment for any medical student. Over the next few months, we met regularly to develop a research plan. As a medical trainee, the presence of older white men in positions of authority is almost constant—so routine that he easily had my trust as a mentor, advocate, and sponsor. I saw nothing wrong. And likely you saw nothing wrong. We had just finished a meeting to solidify the project idea. We exited the building to a sky covered in a thin blanket of clouds. As we were crossing the street to head to our respective cars, he stopped, turned toward me, and casually asked, "What are you doing after this? "Oh, I'm going shopping for a suit for an interview." He paused. "What color are you thinking?" "I dunno. Probably gray?" He stepped toward me and said, "Send me a picture of you wearing it." Suddenly I saw our relationship in a harsh new light. His smile was sly and he was standing closer than usual. He did not touch me, but there was an unsettled weight in the moment" (para. 1-9).

Her story ends with "mentorship has great positive potential, but it is also ripe for misuse. Sometimes the abuses are blatant; sometimes the harm is more subtle. In all cases, mentees need to feel protected by their institutions to speak up" (Landry, para. 16).

In addition to potentially abusing their role as senior staff, seasoned physicians often cite concern around showing emotion or any sign of weakness in their role, including seeking support for mental health disorders, due to stigma, fear of losing their licence, losing the respect of colleagues, and at times, the personal belief that physicians do not suffer from mental illness (Rimmer, 2019, p. 1). The stigma associated with feelings and mental health in medicine contributes to the social indoctrination of learners who then seek to remain detached, lest they burn out. Dr. Rana Awdish reflects on her own medical school experience, saying,

> "I felt like I wanted to fit in during medical school. Medical students are young, and there is this club you've wanted to join your whole life. If someone tells you implicitly or explicitly, 'This is how we talk in this club, and this is how we act,' you start to adopt those behaviours if you want to fit in. What I can say is that it never felt comfortable to me. It never felt good or like we were advancing the care of the patient when we distanced ourselves from the emotional impact of patient suffering and patient care. I think part of what we don't talk about in medicine, especially as women, is that we're representing a traditional male archetype in medicine, a sort of stoic, unfeeling, distant father figure" (Viswanathan, 2018, para. 12).

John Hopkins physician Elizabeth Dzeng shares this sentiment when she writes in a blog post from 2013:

> "[I]t was the motto of my medical school's residency program: Aequanimitas. Based on an essay of that title by Sir William Osler, it means unperturbability. They urged us to become that ideal doctor who had that, 'coolness and presence of mind under all circumstances, calmness amid storm, clearness of judgement in moments of grave peril, immobility, impassiveness'. It was these doctors who had the expertise to heal their patients, not ones who were so 'weak' as to weep with a patient during life and death situations" (Dzeng, 2013).

While Elizabeth Dzeng's account is only one example, her experience with medical education is demonstrative of a much larger phenomenon within medical institutions, both academic and clinical. The phenomenon I refer to is the lack of respect for, and allowance of, natural human emotion experienced by caregivers and caretakers in the workplace. There are many reasons for this, but we can get an initial sense of what beliefs contribute to such protective and repressive actions when we look at data like Dzeng's account, and evidence from McKegney and Rimmer. The unconscious and pervasive cultural logic seems to go as follows (as derived from my autoethnographic data):

Premise 1: Doctors don't cry, because crying is a weakness.
Premise 2: There is no room for weakness in medicine.

Premise 3: Weakness is not a quality of the competent physician.
Premise 4: Crying affects your ability to provide care and diminishes your professionalism.

Conclusion: Physicians who cry are not fit for the job, they are weak and unprofessional, and will thus not be accepted by their peers (who want to appear successful), and these physicians will fail their patients due their emotional incompetence.

This above example is a hypothetical series of reasoning, and it does not fully capture the complexity of internal reasoning that truly takes place for each caregiver or healthcare worker. Instead, this is an exaggerated thought process that I feel captures the spirit of the various ways caregivers will act, speak, and think about things in their workplace. It is also a way that I have personally thought about medicine, given my own experiences.

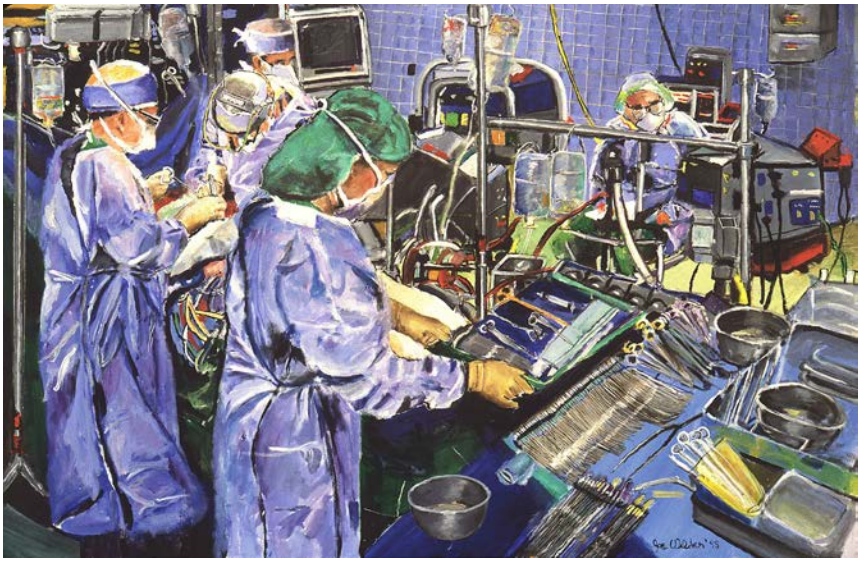

Figure 10: *Cardiac Surgery*, Painting by Joe Wilder, MD, Director of Emergency Services Mt Sinai Hospital New York (Wilder, n.d.).

I stood beside the anesthesiology resident, Sarah, as we went over the numbers on the monitors and discussed the patient's needs. “See, this is where you can see the vitals, and their sats, and let me just grab some meds from the drawer, we want vasopressin,” she said hurrying from one side of the patient's head to the other. She was welcoming, and excited to show me and my friend Anna what she was doing. This patient was an organ donor, and they were donating almost everything. Teams had flown in from across the country, although only within a few hours’ radius (since organs can only be outside the body for so long, only some provinces can retrieve them due to their distance away) and everyone seemed excited. The big blue sheet was between us and the surgical staff, so it felt somewhat private with Sarah. She explained what was going to happen as Anna and I made ourselves at home behind the patient's head. I glanced over the blue sheet to see the patient lying there, ready for the abdominal incision, their skin glistening like pure white porcelain. I noticed how their eyes were dark, like racoon eyes – as if they had a mask on. "Why are their eyes like that?" I asked Sarah. She said, "Yes, they have a severe head injury and brain trauma."

The case was progressing smoothly when Sarah asked me, "Would you like to irrigate the lungs for me?" "Oh wow," I said, shocked at the offer, "Okay... what do I do?" She handed me a tubular wand that looked like a suction device, except it spat water, it was like what the dentist uses to rinse your mouth out. She asked me to insert it through the bronchoscope to rinse each lung with saline solution. At first, I noticed how awkward it felt to try to fit my hand into someone's gaping mouth, the sharp edge of their teeth gliding across the back of my hand and declaring the limited boundaries. The passage down their throat was a long pink rabbit hole, that seemed to get darker and darker as I descended it. I was so gentle, I barely wanted to scratch the surface of the patient's delicate skin, I did not want to *hurt* this person. However, it was a strange thought to have because I knew they were already 'dead'. But I could tell, everyone was treating this person gently and were thankful for their gift.

Midway through the case Sarah explained how we could take a break soon, except the break would never come. Soon after, she received a page for a patient who was coding on the floor. "Let's go!" She said, having clearly taken us under her wing as the most responsible den mother. We left the OR and followed her up a few flights of stairs to a patient's room, who was already surrounded by many other healthcare providers. The patient seemed okay, they were not actively in cardiac arrest, so they must have just had an irregular rhythm and perhaps couldn't breathe easily. Sarah inspected the patient, talked with the team, and calmly made sure everything was okay before she decided that we could head back to the OR. When we arrived back, the team was still deep in the patient's abdomen, so we took a minute to inspect the strange egg-shaped machine that the kidneys were awash in as the team lead walked us through its processes.

Eventually, the surgical team had successfully retrieved the kidneys, both lungs, and the liver, and the cardiac team was ready to take the heart. My friend and I briefly abandoned Sarah who was behind her curtain, as we wanted a closer look at what the retrieval team was doing. They had to keep the patient on bypass while they waited for the cardiac team across the hall to catch up. There was a lot of blood suddenly, and I heard the surgeon say, "Well, there goes the spleen," as they pulled a blackish-red mush out of the patient's belly. Just then, I started to notice my friend beginning to fall slowly towards the floor as her legs buckled under

> her. “Anna!” I blurted out. “I’m fine,” she said, “I’m fine, I just feel a little lightheaded that’s all.” The team was quick, the nurses said later that they can always tell when someone is about to go down. They all laughed and said it was completely normal. Later, in the locker room, she explained to me how she was embarrassed, and how she wasn’t bothered by the case. I said, “It’s okay, I understand.” She said, “No really, I can handle it, it wasn’t the blood and stuff that got to me.”

I knew how my friend felt, it was embarrassing to show weakness in the OR, and even if she wasn’t bothered by the blood, she was clearly bothered by what the team thought of her. Certain members of the team did seem to enjoy joking with people who were affected by surgery. It seemed to be a badge of honour to be able to shake off the crazy scenarios that surgical staff faced, but no one ever said this aloud, they didn’t tell you “When you enter here, check your emotions at the door.” Truly, they didn’t need to say anything, instead, they modelled this for us unconsciously. Surgical staff are confident, stoic, determined, and assured, they do not present themselves as emotional, nor do they show their cards easily. This disposition was built throughout their career and is one that students can quickly mirror back to them. My friend told me months later, “It’s my blood sugar, I found out that I need to eat a granola bar if I’m in the OR for over four hours.” I laughed, and said, “Oh good! I’m glad you figured that out, I think it was just standing for a long time, you had postural hypotension or something, like the military on parade!” She did, in fact, just have low blood sugar. What I will always remember was when she spoke up about the team's perception of her fainting, as that was a clue for me about how our culture had affected her.

5.2 Emotional Repression

Part of the inspiration for Elizabeth Dzeng, who wrote about Aequanimitas above, was an article published in the New York Times by David Bornstein entitled *Medicine’s Search for Meaning* (2013). Dzeng claims that this article “resonated tremendously and brought these memories back to the fore” (Dzeng, 2013). Bornstein’s article draws on expertise from Dr. Tait Shanafelt (Director of the Stanford WellMD Centre and Chief Wellness Officer for Stanford Medicine) and Dr. Rachel Naomi Remen, creator of The Healer's Art (a holistic model curriculum for medical schools), to argue for the benefits of “an alternative socialisation process;” one that will better prioritise a community of healthcare providers who support each other and can express themselves freely to authentically connect with patients through empathy and compassion (Bornstein, 2013). Bornstein writes that medical training “places unrealistic expectations on students, keeps them sleep-deprived, overstressed, and in a state of fear of making mistakes, and sends the message that doubts, or grief should be kept to oneself” (Bornstein, 2013). In Bornstein’s article, Dr. Remen recounts her training as an intern:

> "After medical school, on her first day in training as an intern, a 3-year-old was brought into the emergency room after a car accident. The doctors were unable to save the child's life. Remen accompanied the chief resident as he met with the parents to inform them that their child had died. When they broke down, the sadness was too much. Remen found herself crying, too. Afterward, the chief resident took Remen aside and said that her behaviour had been highly unprofessional. The message stuck. By the time Remen was a senior resident, she hadn't cried for years" (Bornstein, 2013, para. 11).

She reflects on how this comment affected her practice for years afterwards, even though it was only a single exchange, this physician's words had imprinted upon her identity and shifted her priorities, which affected how she presented her values to the world, no matter how she was really feeling. In the same year, another child died from drowning, and she was again presented with the task of letting the family know the tragic news. She remembers how when the parents "held each other and fell apart sobbing — she stood silently by in her white coat, maintaining her professional distance. After a while, the baby's father, with tears running down his face, apologized. 'I'm sorry, doctor,' he said. 'I'll get a hold of myself in a minute.'" (Borstein, 2013, para. 13). She asked herself, "How had she become the person a grieving father apologizes to?" (Borstein, 2013, para. 14).

If we recall the concept of trauma-informed care, we might consider how stress-related reactions and emotional outbursts should not be viewed as a person's *fault*, instead, we might consider *why* a person is feeling that way (i.e., what happened to them?). We also need to account for the emotional diversity of individuals (e.g., neurodiversity, emotional intelligence, and/or level of self-awareness) because not everyone is wired the same way, and not everyone is emotionally identical. Further to this, some people are not well-practised in emotional self-awareness and cannot tell when stressful feelings are bubbling up until things escalate, or people may not have the situational awareness to realize how their actions increase the stress of those around them. Emotional stress is a strong force that affects our thoughts, beliefs, actions, and behaviours (e.g., facial expressions, outbursts of anger, crying, or yelling). Stress can also be palpable, it can create a mood, an atmosphere, and it can hang onto us tightly, seeming to refuse to let go once it's gotten a hold.

Arguably, Dr. Remen's experience of having to disclose the deaths of many young children to their parents is traumatising. As previously explored, the effects of exposure to trauma can be devastating, and at times irreversible. For some, processing traumatic events might be more expedient, whereas, for others, the effects of trauma can linger for longer periods negatively affecting daily life, even affecting decades of that person's life. As a reminder, the American Psychological Association (APA) defines trauma as "an emotional response to a terrible event like an accident, rape, or natural disaster" in which "immediately after the event, shock and denial are typical;" whereas "longer-term reactions include unpredictable emotions, flashbacks, strained relationships, and even physical symptoms like headaches or nausea" (2022). Individuals who have "pre-trauma risk factors," such as a high psychological burden, i.e., they have been repeatedly or consistently exposed to trauma (e.g., childhood abuse) or have a history of mental health disorders such as anxiety, depression, post-traumatic stress disorder (PTSD), or dissociative disorders, are at greater risk of incurring further mental damage and PTSD after subsequent traumatic experiences (Kessler, et al., 2014, p. 273). In this case, dealing with trauma alone or through the support of family and friends may not be enough, and professional help becomes required.

If a person is lucky, they have experienced very little trauma in life or have had the appropriate support available when attempting to deal with trauma-related emotions. Unfortunately, avoiding trauma altogether is the only surefire way to escape its damaging blows, but this avenue is rarely possible. Most traumatic events (or situations) happen unannounced and are unpredictable, making them impossible to avoid. Heart attacks and terrorist attacks are never planned, even if their occurrence can be somewhat predicted. Children cannot choose their parents or advise them on how to best care for them, they also do not know how to identify abusive or inappropriate behaviour to protect themselves from it. Smaller, or what we might consider more innocuous experiences like words said to us, or sights seen on television shows, can also invoke trauma responses. Individuals may even dread the threat of possible trauma, whether their concerns are rational or ever materialise. We also do not have a choice in deciding what will traumatise us, because we do not typically know what will be definitively traumatising. We may be aware of having a fear of snakes or spiders, or that gory movies are difficult to watch, so we take precautions around these subjects. Or we may purposely expose ourselves to things that upset us, i.e., exposure therapy, only to feel the effects of this later on.

In terms of shock and denial when faced with the immediacy of trauma, individuals may hide or block their true emotions in the moment to cope. The most dramatic form of this coping would be to *disassociate*, a "normal process that is initially used defensively by an individual to handle traumatic experiences [that] evolves over time into a maladaptive or pathological process" (ISSTD, 2011, p. 119). General dissociation or dissociative identity disorders (DIDs) serve to encapsulate the trauma, as it is thought that traumatised individuals might fragment part of themselves to avoid fully experiencing or acknowledging the trauma. This can later affect the continuity of their lived experience in terms of the access that person has to their own memories, beliefs, and emotions (ISSTD, 2011, p. 122).

Identity disorders lie at the extreme end of the spectrum and are often related to egregious forms of early childhood trauma, however, what is considered to be peritraumatic dissociation can occur with anyone who is exposed to trauma. McDonald et al. (2013) write that "peritraumatic dissociation potentially involves disturbed awareness, impaired memory, or altered perceptions during and immediately after a traumatic experience," responses which are considered "very common in the immediate aftermath of trauma, with common reports of emotional numbing, reduction in awareness of one's surroundings, depersonalization, and amnesia" (p. 1). McDonald et al. remark that "one of the major reasons much attention has focused on peritraumatic dissociation has been the strong relationship it has with subsequent posttraumatic stress disorder (PTSD)" (2013, p. 1).

Trauma caregivers and emergency healthcare providers, critical-care workers, and first responders, to name a few, are faced with a dilemma in that their jobs consist of voluntary and continual exposure to traumatic events. Their work is specifically to care for critically injured, critically ill, or dying patients – daily. They must witness penetrating or blunt force traumas from motor vehicle accidents (MVA), recreational injuries from skateboarding or skiing, burns from fire or chemicals, as well as patients who suffer from sepsis, heart attacks, shock, stroke, respiratory failure, the list goes on. These patients are technically difficult to deal with in terms of their medical instability (they often have high mortality rates) and can be traumatic to care for because they are likely to endure a lot of pain and suffering. There may be added political or ethical sensitivities intermixed with the medical care of trauma and ICU patients, e.g. those who have been shot, stabbed, or hit by a car; they can be victims of crime or carelessness, inmates may arrive having been badly assaulted, even patients who have attempted suicide present with difficult histories and/or mental health diagnoses.

Dealing with patients of this nature is emotionally intense. Imagine the range of emotions you might have when witnessing the patient who has several open fractures, the patient with multiple stab wounds, or the patient who is haemorrhaging blood out of their mouth only to die shortly after. The environment is also unpredictable, as some patients might be strong, violent, verbally abusive, or mentally unstable, or they may be passive and not speak up enough, suffering quietly. Watching the patients' loved ones fall apart while witnessing the pain and suffering they go through throughout their care is equally heartbreaking. Experiences that have particularly affected me over the years have been witnessing the wailing and crying of mothers over the death of their children, or partners who fall to the floor in disbelief that death has occurred. For healthcare providers, being able to appropriately engage with these strong emotions, and remain healthy, that is, discharging them openly in a safe and accepting environment, as well as doing so in a timely manner, is important for avoiding PTSD (Kessler, et al., 2014, p. 266).

5.3 How Resilience Factors In

To address occupational stressors and other harmful contributors to unwellness, evidence suggests that both organisations and individuals have a role to play in shifting the scales towards *resilience*. The term "resilience" has become a prominent response to burnout (Epstein & Krasner, 2013; Hanson, 2018; Rushton, 2018, Seo, et al., 2021) as it has been proposed by researchers as an antonym to BOS. It is this quality of individuals (i.e., to be resilient or to show resilience) that is thought to help them avoid BOS or recover from occupational stress. The literature on resilience looks closely at individuals who appear to be thriving in harsh conditions – and asks – what traits or strategies are these individuals employing? (Milne, 2007). This approach assumes that resilient individuals are already coping better than others, meaning, the goal is to discover their secret.

What does it look like to be resilient in the face of difficulty, and what is resilience? The traditional definition of resilience is quite simple, as the Oxford dictionary indicates, "resilience is the capacity to recover quickly from difficulties;" however, a more thorough clinical understanding of resilience has been difficult to pin down (Wong & Olusanya, 2017, p. 334). Lee and colleagues (2015) write that resilience "is the ability of an individual to adjust to adversity, maintain equilibrium, retain some sense of control over his or her environment, and continue to move on in a positive manner" (p. 423). A more literal definition of resilience is "tending to resume the original shape or position after being bent, compressed, or stretched; hard-wearing because of being able to recover after the application of force or pressure," and more figuratively, resilience "of a person, the mind, etc." as defined by the Oxford English Dictionary, is "tending to recover quickly or easily from misfortune, shock, illness, or the like; buoyant, irrepressible; adaptable, robust, hardy" ("Resilience," 2023). I am curious if this is what we want from caregivers, i.e., to become hardened to trauma, or to let things easily bounce off them.

Researchers have attempted to pinpoint the coping mechanisms that are used by resilient individuals and have sought to determine which personality types are already resilient, or which psychological strategies have been successful in making them resilient (Mealer, et al., 2014; Ntantana, et al., 2017). It is also important to know if resilience can be taught and learned by others, or if it is simply innate. Resilience appears to be both something that is intuitively practised, as well as something that can be learned and then practised. Mealer et al. list ten psychosocial strengths shown to increase resilience for ICU nurses (which can be learned) which include: "optimism, developing cognitive flexibility, developing a personal moral compass or set of beliefs, altruism, finding a resilient role-model or mentor, learning to be adept at facing fear, developing active coping skills, having a supportive social network, exercising, and having a sense of humor" (2012, p. 297).

Wong et al. write that certain skills are shown to be related to resilience, such as expressing gratitude more often (as this can generate positive emotions for everyone involved), spending more time developing bonds with friends and family, keeping a personal diary, and spending time knowing oneself (i.e., meditation, personality testing, and developing a sense of purpose) (2017, p. 338). Other features that contribute to resilience, which I have drawn out from my data and experiences on the organisation of a unit, include the development of personal autonomy over one's role, better team-building exercises, dissolving conflict amongst staff, the use of ethics support and counselling services, and securing a sense of trust between management and frontline workers. These examples point to the idea that resilience is both a state of mind and a practice that must be done in a supportive context.

Importantly, there exist both individual and organisational level factors that may determine the degree to which the development of resilience is possible. Individual factors include intersectional facets, such as age, sex, degree of social support, knowledge and practice of coping strategies and one's personality. Traits such as neuroticism, anxiety and insecurity play a major role (Wong, et al., 2017, p. 335). Organisational factors include work-life balance, lack of control in the workplace, unclear job expectations, and colleague culture and dysfunction (Wong, et al., 2017, p. 336). Cynda Rushton, a professor of clinical ethics at John Hopkins Hospital and University and author of *Moral Resilience: Transforming Moral Suffering in Healthcare* (2018), has taken this problem very seriously and has implemented a moral resilience training program to enhance competency in nurses which she called the "Mindful Ethical Practice and Resilience Academy" (Rushton, et al., 2021, p. e1).

The major risk factors associated with low resilience include an increased risk of post-traumatic stress disorder, an increased sense of anxiety and depression, a tendency to isolate and detach from others, increased medical errors, conflict in the workplace, substance abuse, and even suicide (Wong, et al., 2017, p. 336). Conversely, high levels of resilience correspond with lower levels of burnout, depression, absenteeism, and stress, as well as an increase in general wellbeing and overall ability to bounce back from stressful situations (Lee, et al., 2015, p. 423). What is unique about resilient individuals is that they may not even recognize situations as stressful in the first place, Rodriguez-Rey and colleagues (2016) state that they "are less likely to perceive difficult events as traumatic" (p. 408), perhaps pointing to personal perception as a key feature of resilience.

Rushton says that "if one is morally resilient, it is possible to find ways of addressing moral suffering and distress that overcome their negative, debilitating aspects. As spiritual, religious, and humanistic traditions hold, growth is possible, even after traumatic events. Yet, for those who are morally, and emotionally depleted or dispirited, moral resilience may be inconceivable or even objectionable, provoking intense resistance to consider any constructive outcomes arising from moral distress" (p. 105). This means that people who are already suffering the consequences of burnout will be less likely to be able to hear why resilience is important, as they are not in the right headspace to truly listen or take on emotional work. Building resilience takes time, and it is not something that happens overnight.

Rick Hanson, author of *Resilient: How to Grow an Unshakable Core of Calm, Strength, and Happiness* (2018) argues that "simply having useful, enjoyable experiences is not enough," the real path to resilience requires remodelling the brain by learning new ways of processing events and developing new psychological resources over time (p. 2). Hanson feels that the "central weakness in much of positive psychology, human resources training, coaching, and psychotherapy" is that they do not convert these experiences into "lasting change in the nervous system" (p. 2). Additionally, Dean, Talbot and Dean (2019) believe "the solutions reside not in promoting mindfulness or resilience among individual physicians, but in creating a health care environment that finally acknowledges the value of the time clinicians and patients spend together developing the trust, understanding, and compassion that accompanies a true relationship" (p. 401).

I have witnessed first-hand the resistance to resilience when this term is presented to healthcare teams out of context, making it sound like toxic positivity. According to Shipp and Hall, toxic positivity is rooted in positive psychology, where “positive psychologists emphasise the power of positive thinking” (2024, p. 2). Proponents of positive psychology vouch for concepts “that positive thinking, attainable happiness, and learned optimism directly influence and even produce positive outcomes” or suggest that “positive thinking, verbal affirmations and learned optimism as interventions for the treatment and prevention of psychopathology” (Shipp & Hall, 2024, p. 2). The critiques of positive psychology centre around the concern that this philosophy denies negative experiences, it puts a lot of pressure on individuals to successfully control their thoughts and feelings (or else they have failed to be positive), and lastly, this strong emphasis on constant positivity can create a sense of disillusionment when positivity fails to produce an idealised version of one’s life “leaving people frustrated, disenchanted, and damaged” (Shipp & Hall, 2024, p. 2).

Similarly, the promotion of resilience (in its thinly portrayed abstract form) in hospitals denies the lived experience of caregivers who are suffering in today’s medical climate. This term can even make caregivers feel gaslit.

> I can recall very clearly a discussion I once had on the topic of resilience with a group of nurses who I was delivering a presentation to on burnout and moral distress. This particular presentation happened just after the worst bout of Covid-19 in our hospital, at a time when we had high attrition rates, and the nursing staff were exhausted. As I walked the group through the various demands their jobs place on them, and how this can be damaging to their health, I finally came to my slide on resilience. As the slide loaded, it read “Then you are asked to be resilient…” Since I was facing the nurses, I could see their facial expressions – which included blank stares, eye rolls, and some frowns. The group was silent for a few seconds. I then said, “Now, I do not necessarily think this term is helpful right now.” I then saw their relief, and they began talking and sharing their experiences. One nurse said, “I just don’t want to be resilient right now,” and another said, “After everything we do, it’s not that we aren’t resilient, it's that we are constantly being asked to do more with less, and it’s not possible.” Another nurse explained, “I was part of a presentation recently that told us to be more resilient, and it was gaslighting… they were telling us how to manage our jobs when we are really good at that. We know what to do, we just need some humanity thrown our way… we need some help from management to have the resources and support we need after a long gruelling shift.” Finally, a newer nurse who had only been working for a year said, “I’ve only been doing this a short while, and I’m already done, I’m ready to leave the profession.”

Shipp and Hall give examples of this approach: “reassuring staff members that all is well, telling them to think happy thoughts, insisting that failure is not an option, or suggesting that it could be worse, and everyone should just feel grateful” (2024, p. 7). Even in saying ‘resilience’ to caregivers, I have noticed their eyes glaze over, as it is viewed as a superficial motivator. Phrases like “you just need to be more resilient” can bring up uncomfortable questions, ones that push caregivers to think “Why am I not resilient?” “What is wrong with me?” and even “Why can’t I be better at my job?” Toxically positive messages promote the expectation that resilience is something that can be bought, borrowed, or sold for caregivers to “heal thyself” (Shipp & Hall, 2024, p. 7), rather than the truth which is that resilience “is not a fixed state,” it “dynamically matures and grows or declines depending on the characteristics of the individual and the ecosystem around [them]… people may be resilient at some times and not others, depending on the circumstances they find themselves in and their personal profile and capabilities,” and that people will require support from their community and their organisation (Rushton, 2018, p. 106).

Often, critical care staff have very little control over their environment and very little time to process their circumstances. Patient admissions and discharges from the unit can be frequent and unpredictable, one's knowledge of when a patient will suddenly decline may be unforeseen, and patient deaths can be long and drawn out, or disturbing. A prominent point of stress for critical caregivers is that when their patient dies, they are often given no chance to mourn their patient's death or grieve the loss, they are simply given a new admission, sometimes only moments after their patient has passed. This means that they are expected to keep working, suppress their initial emotions towards the recent death, and give their full emotional attention to the next patient. This practice is well recognised in the ICUs where I have worked, and staff frequently comment on how difficult this is. This practice devalues the nurse's personal feelings and sends a very clear message that there is no space for emotion during the workday.

> Whenever I walked into the ICU, I would always take a quick glance around the unit first, to determine if anything important was happening. In my job, where I was responsible for collecting data on all the patients admitted to ICU daily, it was important to catch patients before they left the unit – to record their daily activities of care and to catch any significant updates related to their health and treatment. Common problems for us included catching patients who were discharged from the ICU just as we were arriving for our shift, such as patients who were being transported for procedures (e.g., surgery, MRI, CT) which could last hours, as well as patients who were deceased and needed to be transferred to the morgue. One day, I noticed that a patient had a white sheet over them, and there was some commotion around the bedside. I grabbed my computer and rushed over to see them since I knew security would soon be there to take the patient’s body and their chart. The nurse looked very stressed,

> so I tiptoed very carefully around them, ensuring not to interrupt their workflow or the family who had just said goodbye. It was a delicate dance that I always had to manage in my job, collecting the ICU data, while also remaining polite, caring, and ideally, *invisible*.
>
> My job was important in that having good data helped us to improve care over time; however, my job was also the least important role as it did not relate directly to care delivery. When a patient dies, the most important thing in that moment is to comfort the family, be respectful, pay your respects to the patient who has passed away, and give the healthcare team all the space and support they need. On this day, the nurse was running around trying to complete the death package, while also listening to the charge nurse who was explaining that the life-flight team (the helicopter that transports critically ill patients) would be arriving any moment with a new patient for them. She gave their history and explained how this patient was found pulseless in their bedroom, and after several rounds of CPR was resuscitated, but now needed a scan to determine the extent of their brain damage or hypoxia. I could tell the nurse was trying to comfort the family of her patient who had only died 30 minutes prior, but she also had to prepare the room and herself mentally for the next patient coming in behind them… This type of situation happened *all of the time*.

Relatedly, evidence shows that it is not simply an increased exposure to death that creates burnout or hinders resilience in the ICU setting, otherwise, palliative care would be the focal point of this discussion. Palliative care staff have often explained to me how caring and sensitive they are to patients before their death, even going to great lengths to ensure privacy, comfort, time with family, music therapy, and special wishes, which are granted before the patient's passing. Comforting patients at the end of their lives is an important part of palliative care. The culture of the ICU differs from this imagery greatly, where critical care staff are faced with constant rushing, difficult conversations, ethical dilemmas, workplace bullying, aggressive messy interventions, long working hours, and limited resources, all of which create a much different atmosphere for patients and providers (Wheeler, et al., 2018, p. 279). In palliative care, patients may be under a warm blanket, surrounded by family and music, whereas in the ICU they might be alone in a sterile room while another patient is crashing beside them.

Insights into how to build more resilience in the ICU setting have also been gained through research in Nova Scotia by Hancock, et al. who outline (1) what their ICU team has explicitly expressed they would change to feel better at work, and (2) what has already shown to improve their experience related to moral distress and burnout thus far. From evidence gathered in focus groups, Hancock et al. asked caregivers how they felt towards different workplace stressors. Their responses were recorded, and the audio files were transcribed verbatim, then coded using software, and organized into themes such as end-of-life care, workplace autonomy, and toxic relationships etc.

(Hancock, et al., 2019, p. 8). They discovered that some healthy coping strategies were identified by the staff which included "leaving work at work, exercise, family and pets, hobbies, humour, socializing outside of work, and talking with peers" (Hancock, et al., 2019, p. 41).

In terms of "building better resilience," staff requested more consistent and sufficient staffing levels to ensure a safer work environment; a better investment in nursing education, especially when it comes to using complex technology such as renal dialysis machines and new pumps, or to be included in morbidity and mortality rounds; additional infrastructure, such as access to a gym, and better/healthier cafeteria food; more frequent debriefings after a traumatic incident; mental health recovery days rather than feeling the need to abuse sick time; destigmatizing the need for help; long term follow up with ICU patients; and overall, promoting a just culture, with a focus on decreasing workplace violence and bullying, and increasing managerial engagement (Hancock, et al., 2019, p. 43-50). The above suggestions provide a helpful starting point for us to envision how to positively change the ICU lifestyle, but we must also remain aware of what these changes require for them to be effective and helpful.

> The patient had just died after 1 full hour of CPR. The entire critical care group was tired and huddled around the nursing station. The physician called an impromptu debrief and asked everyone to gather to discuss the care that was just delivered. "Okay everyone, let's go around the room and get some first impressions," he said, looking around at the faces in the circle, who were currently silent. A minute passed, when finally, someone spoke up "I think it went well," a nurse started, "The whole team really pitched in, and I never felt like I needed to ask for help." Another staff member chimed in, "I agree, I felt like there was an unspoken energy in the room, people just kept lining up for compressions, I never had to go find someone or yell out for help." The room was somewhat quiet again, until a respiratory therapist also spoke up, they said "I will add that I also found this really smooth for a code, I had good access and support." The physician followed up, "Okay great, I also think this was a really good code, the whole team pitched in, and we did everything we could to help this patient."
>
> Just then, a nurse raised her hand and said "So, I just wanted to express how… um… stressful it was, with the family," She paused, "I've never seen a family so upset to see their loved one being worked on like that… and with the screams and cries…" the nurse said as she began to tear up, "It was really sad…" She said through tears, while continuing to talk, "I find it's really hard to watch that and then move onto the next patient, and I got an admission right after…" The charge nurse spoke up, and told her, "Yes, I just had two sick calls today, so I needed to…" The nurse gently interrupted to say, "I know, it's just this ongoing battle, moving from one patient to the next without any time to decompress afterwards." Her tears were dry

> now and were met with silence from the group. The debrief ended, and a few people thanked her for her contribution, the staff dispersed, and things continued as normal.

This story is an example of positive change, whereby a physician took the initiative to provide an impromptu debrief for the staff to help them – which is a rare occurrence – and I commend them for this attempt. However, the structure of this debrief was very loose and ill-formed, and it had some inherent problems. It was run by a powerful member of the group (which may have prevented staff from freely speaking up), it was run in the middle of the ICU where patients and other staff members were walking around (preventing a comfortable and safe space to discuss together), and lastly, there were very few moments where staff were encouraged to speak, or were validated for how they were feeling. This example demonstrates how practice is required to do this work, and how emotional work cannot simply be tacked onto the medical day, emotional work is worthy in its own right and requires space, privacy, sensitivity, and time.

In my own experience over the years, I have noticed additional, yet subtle activities that staff reported as helping them to feel better at work. One nurse told me the simple fact that being *heard* was important to her in being able to reduce feelings of stress and exhaustion. Essentially, it was not enough for her to go home and tell her husband what was troubling her about work. Instead, what truly helped relieve the anxiety and feeling of futility was having someone who could both listen and understand, something that could *only* be provided by a fellow nurse on the unit. During ethics education sessions, the primary feedback that was expressed by staff was the feeling of relief that was felt from being given a platform on which to have moral discussions at all. Nursing staff unanimously agreed that being able to connect with their peers in the same space to discuss difficult issues provided them with new knowledge (when hearing the perspectives of others), and validity as their own fears and anxieties were reaffirmed by others who claimed to have suffered from the same or similar issues. Mealer and colleagues (2014) write that “it was comforting to learn that fellow nurses had similar reactions to traumatic experiences at work, and the group sessions made nurses feel less socially isolated and more connected with their peers” (p. e103).

When considering how to implement programs to build resilience in the ICU there are very clear hindrances to overcome, including time constraints for nurses and physicians, space and appropriateness (e.g., we cannot conduct a yoga class in the middle of the ICU, or bring in therapy dogs due to infection control regulations), the need for voluntary consent and buy-in (if staff feel that resilience training is futile they may not want to partake), lastly, the fact that there is little evidence to prove which strategies will work best (and trial and error would be a waste of everyone's time). Mealer, et al. offer some hope as they indicate from their study that the implementation of a resilience training program was considered to be both feasible as well as acceptable by ICU staff (2014, p. e103). This does not mean that solutions to work-related stress are not time-consuming, and participation in resilience training must still be voluntary. Many of the solutions that have proven to improve resilience do require dedication, persistent effort and focus, and cooperation from everyone on the team.

The larger global literature on resilience supports evidence for macro and micro changes that need to take place to support practitioners working in high-stress environments such as the ICU or PICU. The research trends suggest that staff should seek to engage in peer mentoring, peer-to-peer discussion, and social gatherings with coworkers, when possible, as these coping behaviours have proven to be effective. An additional reason that it is important to engage specifically with other ICU staff is because sometimes ICU stressors cannot be as well understood by "outsiders" (Lee, et al., 2015, p. 427). Due to the staffing structure of shift work, night and day call, and one-to-one patient care, staff may not be exposed to certain team members as often, possibly depriving them of comradery, learning moments, and advice from older staff.

Research by Lee et al. showed that staff with more than seven years of experience scored higher on individual resilience assessments (2015, p. 428), and Wong et al. write that "younger workers have had less professional experience and thus less time to develop effective strategies" for coping (2017, p. 335). Coming together as a team has proved to be highly important for wellbeing, which should include gatherings over and above the normal academic and clinical meetings (such as morning rounds, mobility and mortality rounds, family meetings, and moments of direct care). Intensive care staff need a place to socialize together outside of their traditional roles as nurses, physicians, physiotherapists, pharmacists, respiratory therapists etc. Connecting with peers and having moral discussions can provide staff with better language to define their concerns, as well as inspire them to advocate for their needs. Overall, it seems that simple tactics can go a long way in the ICU, such as taking a break from a stressful patient or situation, being relieved from your shift after you've managed a difficult death, and making an effort to congratulate the hard effort that is put forward by ICU staff every day.

Resilience, as a state of being, is highly complex and requires a large amount of awareness, insight, and practice by the individual to care for themselves to foster a deep sense of inner strength and self-knowledge. While resilience can be learned and is highly useful, researchers should avoid looking only at the end state of a worker's resilience or engagement to inform the recovery process of another's state (those who are occupationally stressed, distressed, or burnt out). This is because there are a variety of complex reasons as to why individuals may exhibit resilient traits or not, including childhood and adult experiences (related to safety, community, and nurturing), neurodiversity (or variations in brain structure and chemistry), and other learned behaviours such as the presence or absence of coping mechanisms or support. The "range of psychosocial protective factors in the face of stress and trauma" (Feder, et al., 2019) is an integral part of understanding resilience.

5.4 Empathy: Pro or Con?

Medicine's shift away from paternalism[41] and towards patient-centred care and shared decision-making (which according to Kornhaber, et al., (2016) "requires health care professionals to have the ability to form therapeutic interpersonal relationships that elicit patients' true wishes and recognize and respond to both their needs and emotional concerns" (p. 538)) has not only empowered the patient population, it has also highlighted greater expectations patients have of physicians to be more sensitive, caring and emotionally available. Rajvinder Samra writes that "the benefits to patients when physicians demonstrate clinical empathy are well reported" (2018, p. 991), and the literature on patients who receive empathy often feel listened to, validated, cared for, more trusting, and thus safer under a professional's care (see Derksen, Bensing, & Lagro-Janssen, 2013; Yu, et al., 2022). Additionally, when patients are more satisfied with their interaction, they become more open about their symptoms and are less distressed, leading to improved outcomes (Kornhaber, 2016).

While the literature on the effects of empathy on patients is thorough, the effects of practitioners using empathy have been less well reported in terms of the expenditure of these emotions, the ways empathy makes them feel, and whether it is beneficial or harmful to them. Instead, there are discussions around the literal "price tag" of clinical empathy, and the "additional time often required by practitioners to treat patients" or "the time and money spent training practitioners to enhance empathy" (Howick et al., 2020, p. 390-391). Yet, much has been written about burnout syndrome and compassion fatigue, two topics that often include a discussion on empathy. Moudatsou, et al. (2020) describe how "a relationship based on empathy helps the therapists lessen their stress and burnout in the workplace and adds to their quality of life" and that "It has been shown that physicians who have higher levels of empathy experience less burnout or depression" (p. 3). They also discuss how "Some of the factors that negatively influence the development of empathy are the high number of patients that professionals have to manage, the lack of adequate time, the focus on therapy within the existing academic culture, but also the lack of education in empathy" (Moudatsou, et al., 2020, p. 26).

In my experience, both in the hospital and having studied bioethics for many years, my exposure to empathy in medicine has been primarily geared towards how it affects patient wellbeing. Rarely do I recall encountering discussions about how empathy could affect caregiver well-being. Over

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[41] Medical paternalism was an accepted ethical norm and common clinical practice throughout medical history and can be traced back to the origins of Western medicine. McCullough (2016) defines general paternalism as "the assertion of epistemic and moral authority, and the power such authority justifies, over children by fathers, historically, and parents" and by using the "relevant ethical concepts and principles, the concept of medical paternalism is elucidated, to identify its individually necessary and jointly sufficient conditions: (1) a physician or other healthcare professional undertakes actions designed to limit the exercise of the patient's autonomy (2) on the basis of clinical judgment and decision-making that are reliably beneficence based about how to protect the health-related interests of the patient from the consequences of the patient's decisions and actions based on them" (p. 2157).

the years, my perception remained firmly grounded in the idea that empathy was good for *patients*, but physicians and nurses should be careful, lest they spend all of their emotional energy on patients and become drained of their affective resources. This phenomenon is often referred to as compassion fatigue, "where exhaustion or hopelessness takes over one's work, leading to burnout" (Wagaman, et al., 2015, p. 203). I had experienced vicarious feelings of sadness and fear from patients, and I could feel how these sensations affected me. In my attempts to feel empathy early on, I believe I often only demonstrated sympathy. Sympathy is distinguished from empathy in the following way: empathy is our ability to understand the feelings of another person and be able to show them compassion, whereas sympathy is when we feel bad for someone, pity them, and are glad to not share the same fate. Empathy requires connection, whereas sympathy is self-focused.

I did not feel sympathy for patients because I did not care about them, instead, my sympathy early on was a state of disbelief around some of the situations patients found themselves in, such as being torn apart in accidents, being so frail from chronic illness, or being examined in invasive ways. Inside, I was very worried about their well-being and emotional state, but I now realise that my inability to shift my perspective toward empathy at the time was because I lacked enough emotional stability to begin with. I remained distant and numb because connecting with someone who is screaming in pain might mean feeling what they are feeling, and given my extreme anxiety, taking that on felt unmanageable. My own anxieties and emotional problems became a block for any relational experience I might have with a patient, so everything I did to engage with them had to remain on the surface.

> "How are you today, Miss?" A patient called out from his bed. "Oh, I am doing pretty well," I said nervously, attempting to move along to the next patient. I wasn't used to patients being awake, they were either under anesthesia in the OR, or sedated and 'tubed' in ICU. "How are you?" I asked, trying not to look at their freshly amputated limb. "I am ready to get outta this godforsaken hospital, that's for sure!" He said loudly, "You're some pretty, you think you could get me a glass of water?" "Ah, yes absolutely," I replied, happy to leave the bedside for a moment. I left to grab a Styrofoam cup from the dispenser and filled it with filtered water and brought it back to the patient. I extended my hand trying not to touch his, "Here you go... hope that helps!" He slurped the water and asked, "So, what are you doing?" I brought my computer on wheels (or COW, as we call them) a little closer, "I am collecting information about your care," I said, as I explained my role to him. "See, if you look here, this is where I record your ventilation values, and your daily activity levels." His face had lacerations and bruises, and his gown was turned sideways. "Well, that's interesting," he said as he laid back, falling asleep from fatigue. I closed his chart, put his story out of my mind, and went to the next patient. She was a fully sedated mother of two, she had a brain tumour and

> had recently undergone a craniotomy. “Okay,” I thought, “I wonder what *her* story is?” I opened the cover of her purple chart and began reading.

I often felt some secondary trauma when patients reminded me of myself, e.g., if a young woman died from acute respiratory distress syndrome, or if they had injuries or illnesses that I feared, such as inoperable abdominal cancer. I was also prone to worrying, which expressed itself more prominently in the hospital. One of our ICU patients, who had been admitted for reasons unrelated to shingles, presented with a history of post-herpetic neuralgia or long-term symptoms and nerve pain from having had shingles (a presentation of the herpes-zoster virus). I recently had shingles myself and was still dealing with extensive nerve pain in my side, and I had heard rumours that it could last for years. As I sat in the ICU, sifting through this patient's chart who had died overnight, I held my side as the pain sharpened. I irrationally thought, what if this is a sign that my immune system is failing? Could I suffer from death someday if I fail to get this under control? I *shouldn’t* have long-term shingles at the age of thirty. I took a deep breath and tried to forget about it. I had to know that I was not alone in feeling distress in places like critical care.

> “Repeated exposure to the suffering of others in healthcare professionals may be associated with the adverse consequences of personal distress, burnout and compassion fatigue, which are detrimental to their wellbeing. By the very nature of their work, healthcare professionals encounter people with various injuries and suffering in their everyday practice. In this case, being overly sensitive to others’ suffering and pain may be detrimental and cause several negative effects, such as compassion fatigue” (Duarte, Pinto-Gouveia, & Cruz, 2016, p. 7).

Ben-Porat & Itzhaky (2015) also demonstrate that “a meta-analysis of 41 studies conducted among therapists working with trauma survivors revealed a high correlation between burnout and secondary traumatization, where therapists’ manifest symptoms similar to those of the trauma victims themselves” (p. 607). For many years, I thought that this type of evidence pointed to the fact that medical life is unavoidably difficult and that this type of work (with trauma, injury, and illness) will undoubtedly influence the emotional well-being of healthcare workers, regardless of the strength of their personal constitution. This is an important point since the next question I want to ask is: what were these trauma therapists doing? Were they using empathy or sympathy, or were they disassociating, or feeling anxiety? What was the exact mechanism driving secondary trauma, burnout, or distress? I have always thought it was empathy – Samra (2018) reports that “higher rates of empathetic concern” were expressed by female physicians to patients, who also reported that their medical career negatively affected their personal lives (p. 991). This statement suggests that providers who are more empathetic could be at greater risk, but it is not clear.

Yue et al., (2022) say their research on burnout and empathy shows “the important role that empathy plays in addressing burnout and revealed that managing job satisfaction and increasing the job commitment attenuated burnout” (p. 1033). Even though Samra (2018) argues that the benefit of empathy for patients is clear, they also state that “low physician empathy is associated with burnout and emotional exhaustion” (p. 991). Wagaman and colleagues (2015) show that their “findings suggest that components of empathy may prevent or reduce burnout and [secondary trauma stress] while increasing compassion satisfaction and that empathy should be incorporated into training and education throughout the course of a social worker's career” (p. 201).

The literature on empathy, compassion, and therapeutic connections with patients goes deep and is a core feature of clinical work, especially social work, which is rooted in social relationships. Stanley and Buvaneswari (2016) write that “empathy, emotional intelligence and resilience are three personality attributes that social workers need to consciously develop for effective practice. These attributes not only influence service users but also are important to preserve the emotional well-being and mental health of social workers themselves” (p. 104). Lastly, Duarte, Pinto-Gouveia, & Cruz, (2016) point out that “high levels of affective empathy may be a risk factor for compassion fatigue, whereas self-compassion might be protective” (p. 1). This evidence points to the fact that empathy is connected with burnout and resilience, as long as the empathetic tactics used do not negatively affect the provider. How this distinction is made is unclear. According to Williams et al. (2017):

> “Empathy is a complex, multidimensional concept consisting of both cognitive and affective (emotional) aspects. Affective empathy refers to experiencing the feelings of others, while cognitive empathy is the ability to understand the experiences and feelings of others and being able to relay that understanding back to them. Another key component of empathy, which distinguishes it from sympathy, is self-other differentiation, which is the ability to separate one’s own emotions from those of the other person, which may improve objectivity and help to reduce anxiety and distress” (p. 330).

Empathy is then considered to be the ability of a clinician “to sense the service user’s private world as if it were their own, without losing the ‘as if’ hypothetical quality” (Wilkinson, et al., 2017, p. 19). Wilkinson and colleagues (2017) who conducted a systematic review of studies investigating burnout and empathy in healthcare staff, using five electronic databases, argue that empathy has four key dimensions: emotive, cognitive, behavioural, and moral (p. 19). The first two components (emotion and cognition) are what allow a provider to first *feel* something towards the patient and *understand* the nature of the patient's situation. The last two components include behavioural and moral, which allow the provider to *demonstrate* their feelings and intentions to the patient, as well as to *want* to do something about their illness (the moral aspect) (Wilkinson, et al., 2017, p. 19).

Their evidence showed that even though “findings have been inconclusive in establishing the direction and nature of the relationship” between empathy and burnout, these two terms are both positively and negatively correlated. These authors have also discovered three important qualities of empathy that will help to piece together a better picture of how it functions. First, they write that “service users and clinicians felt *greater satisfaction* with an interaction when there was an increase in empathy;” second, they state that “empathy also *creates vulnerability* for stress-related conditions such as compassion fatigue and professional emotional exhaustion;” and third, the strongest evidence in their research supported the hypothesis that “burnout and empathy were *negatively correlated*, inferring that as the presence of one construct increases the other decreases” (Wilkinson, et al., 2017, p. 19, 20, 27). Either burnt-out clinicians provide less empathy due to their emotional depletion, or with decreased empathy burnout is more likely for caregivers.

Further research must be conducted to assess the deeper relationship between empathy and burnout, to draw more steadfast conclusions. However, some thematic trends are evident, which may help to guide future research questions. In a 2012 editorial by Zenasni et al. the authors propose three possible hypotheses about the nature of the relation between burnout and empathy (Wilkinson, et al., 2017, p. 20):

1. Burnout reduces the ability of clinicians to respond empathetically.
2. Being empathetic draws significantly on personal resources and thus causes burnout.
3. Being empathetic protects clinicians from burnout.

Having briefly outlined the theories of empathy above, I would now like to address each of the three hypotheses. The first hypothesis is supported by the research conducted by Wilkinson et al., as their results show that high levels of burnout were correlated with low levels of empathy (2017, p. 27). To truly understand this outcome is sort of a ‘chicken or the egg?’ scenario since it seems intuitive to imagine that someone who is already suffering from burnout might have trouble producing an authentic empathetic response by being emotionally exhausted; although, a clinician who does not provide much empathy in their practice may suffer from burnout in terms of feeling reduced personal satisfaction and accomplishment. In which direction does this relationship go? The authors argue that it is important to “guard against burnout” by developing ways in which we can maintain empathetic interactions towards patients (Wilkinson, et al., 2017, p. 27). This statement would support the third hypothesis that being empathetic might help to shield providers from burnout syndrome.

The second hypothesis has been supported by most of the other researchers, as they repeatedly state that burnout is highly correlated with empathy, and burnout is correlated with the depletion of emotional resources, for example, Powers and Myers' concept of emotional work. Samra (2018) argues that providers may reduce their level of empathy as an act of survival, she states that “competing time and resource demands… have been identified as hindering emotional regulation” (p. 991). I have heard many times in the ICU "I just don't care anymore" or "I can't care about that right now," not because staff legitimately do not care, but because they feel they have been too depleted of their physical and emotional resources to generate an authentic care response. Samra (2018) suggests that we should both educate and protect medical staff and that by educating medical students early on they will have knowledge of the fact that a high degree of emotional availability will be expected of them. In order to protect current staff, the suggestion is to "focus on the cognitive components" of empathy rather than the emotional ones, suggesting again that empathy is a risk to the well-being of providers (p. 992).

Wilkinson and colleagues do suggest that we need to foster more empathy to protect against burnout, but it was not entirely clear within their reasoning, beyond their analysis, why there is a negative correlation between burnout and empathy. If we think carefully about the idea of 'emotional work,' as defined by Powers and Myers (which will be discussed in section 5.5), a new question could be asked about the relationship between empathy and burnout, which goes as follows: if a provider is unable to produce an appropriate emotional response during a clinical interaction (since they feel emotionally exhausted), what drained them of their emotional resources? Powers and Myers proposed that emotional resources can be depleted when work (an energy expenditure) is involved in producing an emotion that is not already *authentically* felt by the individual since authentic feelings contribute minimally to burnout symptoms because it takes less emotional work to perform during social interaction (2020, p. 160-161). So, what if authentic social interactions do not constitute emotional work, but instead allow for more emotional satisfaction during empathetic engagement? Can empathy indeed protect providers from burnout syndrome?

The instinctive position that continually giving of oneself emotionally is sure to drain personal resources and leave practitioners ultimately depleted and burnt out – is too black and white, since evidence strongly supports the idea that empathetic interactions with patients or clients can be fulfilling and satisfying, and may refuel the practitioner, rebuild their confidence, and bring with it a renewed sense of personal accomplishment. I will re-quote a statement from the beginning of this project that read "Service users and clinicians felt *greater satisfaction* with an interaction when there was an increase in empathy" (Wilkinson, et al., 2017, p. 19, 20, 27). Anecdotally, many providers have confided in me that the interactions they are most grateful for in their medical careers are the ones where they truly connected with people, having used kindness and empathy, while feeling a true sense of purpose having helped them.

> "I'll never forget it," she said, "The patient had a full face of makeup for her surgery, red lipstick and everything!" The nurse was telling me about her shift in the day surgery clinic. She continued, "I told her [the patient], the anesthesiologist is going to smear that lipstick all over your face when they intubate you!" She laughed, "and the patient told me she didn't care, she left the house, so she needed to be put together… couldn't bear to be seen without it… it

> was the funniest moment." She sighed as she reminisced, "I made sure to go see her in the recovery room later and tell her how good she still looked, she was the sweetest patient."

Dr. Rana Awdish writes passionately in her book "In Shock" to advocate for more empathy and connection from practitioners during patient interactions. During her care in the hospital, a physician tells her "I want you to know, I'm not leaving. I'm going to be here all night. We won't leave your side until you can breathe. You are safe" (2017, p. 223). Having been through many tedious and sometimes scary medical procedures and having not always had successful communication with the staff, she says "I thought in those words there was more actual doctoring than in the prior twenty-four hours combined" (2017, p. 223). That is a bold statement on the strong impact empathetic responses can have on patients.

I feel that there is something important to be learned from better understanding the role authenticity has in emotional connection, in the workplace and outside of it. We must seek to better understand the difference between authentic displays of empathetic response from providers, and inauthentic displays of empathetic response. This is because the latter will presumably require more energy, and in a professional occupation like medicine which requires an extremely high degree of empathetic engagement, levels of emotional exhaustion are sure to increase. Practising inauthenticity may create both cognitive and emotional dissonance since people are shown to be happier when the emotional requirements that are demanded of them more accurately reflect the truth of their feelings. Therefore, I support the possibility that being empathetic could protect clinicians from burnout if truly empathetic responses towards patients create less emotional work. More research is required to determine whether empathetic interactions can replenish clinicians' emotional capacities and provide them with a sense of self-actualization and importantly for burnout, accomplishment.

5.5 Feeling Rules for the "Managed Heart"

Arlie Hochschild (1983) talks about emotional work by observing the socialisation of emotional behaviour in people. She references what she has named *emotional labour* in her book entitled *The Managed Heart: Commercialisation of Human Feeling*. Her conception of emotional labour, which she derived from her own socialisation as well as from studying flight attendants for Delta Airlines, is described as the type of exertion, energy, or effort that is needed to fake a reaction or to hide one's true feelings. Hochschild's focus is on workers and the emotional labour required from their occupation, and the ways in which these individuals emotionally process and enact the work they do. Hochschild differentiates emotional labour from the type of physical labour we imagine a child doing in a sweatshop (she references a boy in a wallpaper factory who must exert his body), and the mental labour that is required to safely land a plane, or if you are the flight attendant, to prepare for an emergency landing (1983, p. 5-6). Emotional labour requires the effort of managing one's emotions, where we must seek to "induce or suppress feeling" to sustain the outward disposition, or correct "countenance," "that produces the proper state of mind in others" (1983, p. 7).

Emotional work is not dissimilar from acting, and Hochschild does reference the theatre by drawing on Erving Goffman's (1959) conception of front stage and backstage as an analogy for how people present themselves in public and private (Theodosius, 2008, p. 15). Emotions tend to arise naturally in people and can be hard to contain, especially when we are children and we have yet to become socialised to the emotional expectations of society, as well as when we are faced with strong emotions like fear or disgust. Hochschild uses the term "feeling rules" to describe the expectations that are placed upon us to feel certain ways, such as the expectation of laughter at a party, or crying at a funeral, but not vice versa. This is how we understand what emotional labour is due, called for, or even expected (1983, p. 63).

These concepts are interesting because (1) they recognise first and foremost the integral role emotion plays in one's occupation, and (2) they acknowledge the fact that there is *effort* required to demonstrate specific emotions (when they are called for) in a social situation. Conjuring a specific emotional disposition can be especially difficult if someone is not already feeling that emotion and must produce it (or an impression of it) on command, simply in order to fulfil the requirements of their occupational role (Powers & Myers, 2020, p. 156). Powers and Myers (2020) refer to what they call emotional *labour*, which is when someone must suddenly display a specific emotion (e.g., putting on a happy face when someone is being rude) and emotional *work* is when one must attempt to manage their current emotional state because it does not match the situation (p. 156). We can imagine such emotional work being done in medicine when a nurse must suppress his anger towards a patient who is swearing at him and remain pleasant, or when a surgeon must conceal her anxieties toward undertaking a complex and high-risk surgery to appear calm.

Hochschild, Powers and Myers describe various types of emotional labour that have been studied in the workplace, which include *surface acting*, or modifying your physical expressions to match what is expected, *deep acting*, which is the act of internalising an emotion so that it can be conjured for display, and *automatic regulation*, which is the enhancing or tempering of emotions that already match the situation (Powers & Myers, 2020, p. 158). What is important about these types of emotional labour is that they require energy and focus to perform, and they are an *invisible* type of labour. The results of the research by Powers and Myers concluded that automatic regulation appeared to contribute minimally to burnout, since there is some authenticity involved in this process, as the actor does experience having had the emotion to begin with. Therefore, automatic regulation could operate as a "job resource," because "the closer aligned one's authentic emotions are to the emotion display requirements of their work" the lower the risk of feeling inefficacy (as related to burnout syndrome) (Powers & Myers, 2020, p. 180).

Hochschild defines the difference between surface acting and deep acting as the former being "the ability to deceive others about how we are really feeling without deceiving ourselves," and the latter as "we deceive ourselves about our true emotion as much as we deceive others" (1983, p. 33). From my experience, hiding emotion isn't easy – until it is. In my case, I had been outwardly changing my disposition and countenance for many years before realising the dissociation that was occurring inside of me in the workplace. I often felt the subtle hints of the cognitive dissonance taking place between what I was truly feeling, and how I felt I *had* to act, but my decision to blend in was mostly automatic. As a very young child, I recall having lots of emotions and wanting to express them openly. However, as time went on, I became slowly socialised by my surroundings and the people in my life, particularly my mother, who taught me how to act and react 'properly.' In this case, properly refers to the social and personal expectations my family and parents had of me.

This type of behaviour requires vigilance, and it may start slowly, requiring a general awareness of the rising emotion in our stomachs and the associated beliefs we have formulated around what's appropriate, and what's not, but with practice this behaviour can easily become second nature. This skill progressed at first by having a keen sense of what emotions were "bad" or "uncalled for," which helped me develop a particular distaste for those feelings. Then, I would slowly learn to say "no" to those feelings, by disallowing them to arise within me through stifling thoughts, tears, and my literal voice (e.g., whimpers, screams), when eventually, I had fostered the ability to successfully ignore, repress, bury, mask, or cover up most of my feelings (whether to conceal it from myself or others), a practice that became quite automatic. Eventually, I could not even remember why particular feelings were originally threatening to me, they were just automatically repressed or pushed into the unconscious mind as unpleasant, a response that has been labelled a "repressive coping reaction" (Barger, Kircher & Croyle, 1997, p. 1118).

According to Di Giuseppe and colleagues, "defence mechanisms have been defined as 'unconscious operations that protect the *self* from the awareness of feelings and thoughts of internal conflicts and external stressors' and studied in association with several psychological and somatic diseases" (APA, 1994, as cited in Giuseppe et al., 2020, p. 3). Paraphrasing the work of other scholars, Di Giuseppe and colleagues (2020) also state that "A robust body of literature shows that traumatic experiences are generally related to the high use of neurotic defences… In particular, the defence mechanism of dissociation, (defined as a temporary eclipse of awareness, loss of ability to do something, development of psychosomatic symptoms), [and] is typical of traumatised people" (p. 3).

Hochschild's interest in emotional labour centres around the inauthenticity of the self, the commodification and capitalist exploitation of emotional labour, as well as the resulting alienation that emotional labour produces in people. She concludes that commodifying emotional labour "for profit, ultimately alienates the worker, resulting in inauthentic emotional expression and a loss of the individual's ‘real’ sense of self” (Theodosius, 2008, p. 23). Catherine Theodosius (2008) reviews and summarises Hochschild’s findings, which were:

> “First…[B]ecause their deep acting was so successful, some flight attendants overidentified with their work, seeing their own identity as inextricable from the image that the company set out to portray. This resulted in their being unable to distinguish clearly between themselves and the job, becoming more vulnerable to burnout and stress when speed-up occurred. Second, some flight attendants successfully separated themselves from the role of a flight attendant but blamed themselves for being able only to surface act, making them feel deficient and insincere, and consequently alienated from their work. Third, …[she] found that in addition to distinguishing themselves from the act of emotional labour, some flight attendants also became estranged from the acting itself, seeing themselves as illusion makers: they became cynical and alienated from their sense of self as well as from their work” (Theodosius, 2008, p. 23).

Many key themes which I have identified in my own autoethnographic research here are expressed very clearly by Hochschild in 1983, as she touches upon how a person’s personal and professional identity can blend and become indistinguishable from each other; the ways in which workers may distance themselves from emotionally engaging work, becoming dissociated and depersonalised from others; and lastly, the alienation that occurs in these types of jobs where emotional labour is commodified, as one is separated from the emotion they once produced naturally and is now produced out of obligation and necessity. My concern in the next section specifically centres around how alienation (likely due to the commodification of care, see Chapter 6.5) affects caregivers on a deep personal level, and thus has an effect on their ability to process their emotions in a healthy way, let alone combat the effects of operating within a culture of repression, and in an institution that sees their emotional work as monetizable labour, rather than an inherent good of society.

5.6 The Cost of Alienation

As alluded to, the concept of alienation is important for caregivers who produce caring labour and who also risk becoming estranged from the process and fruits of that labour, so to speak. The idea of ‘alienation’ is perhaps most popularly attributed to Marx and Hegel when talking about capitalist regimes, but this framework can be extended beyond this tradition of thought and applied to medicine – an arguably capitalist entity. In general, alienation is thought to be “a distinct kind of psychological or social ill; namely, one involving a problematic separation between a self and other that properly belong together” (SEP, 2018).

Marx related his theory of alienation directly to the production of labour by the workforce under primarily capitalist regimes. Although the type of alienation Marx discusses is perhaps most pronounced within our current capitalist paradigm, Marx reminds us that this is not the only framework with which to understand alienation, it is merely the framework within which alienation appears to reach its peak state for the working class (Fromm, 1994, p. 43). For Marx, alienation is a process whereby the individuals involved in production become estranged from the very product of their labour. Matt Vidal (2015) writes that:

> "Capitalist societies produce wealth in the form of commodities, which have use-value (when consumed) and exchange-value (when traded for other use-values). Exchange-value is necessarily the form in which value is expressed (and appears). Capitalist production is not driven by consumption (use-values), as Adam Smith and his followers would have it, but by capitalists' desire for accumulation (exchange-values). Capitalists pay workers only the equivalent of their necessary labour time, that is, the amount of time necessary for a worker to produce his or her own livelihood according to the basic standard of living of the era. Any and all additional working time – surplus labour time – is the source of profit. The underlying value of a commodity is determined by the labour time socially necessary to produce it: 'the labour-time required to produce any use-value under the conditions of production normal for a given society and with the average degree of skill and intensity of labour prevalent in that society'" (Marx [1867]1990: p. 129; as cited in Vidal, 2015, p. 650).

The classic example is that of the factory worker, who is thought to be a single cog in the machine that is capitalist production, or, who works to produce material items that become both figuratively and literally estranged from them. These material items, which should be to a craftsman a source of pride, individuality, and creative output, instead become repetitive, dehumanised items of mass production that enslave them as a necessary means of survival rather than a form of self-expression. "The culmination of this enslavement" for the worker "is that he can only maintain himself as a *physical subject* so far as he is a *worker* and that it is only as a physical subject that he is a worker" (Fromm, 1994, p. 84).

The corruption involved in such a process of alienation for Marx is not primarily related to the issue of capitalist gain in terms of monetary objectives (i.e., the equalisation of income), instead, this is about a fundamental estrangement of man from what is thought to be his essential nature. The type of work inherent to capitalist projects is the "kind of work which destroys his individuality" says Fromm, (1994, p. 42) and generates a sense of "misery rather than wellbeing" (Fromm, 1994, p. 85). If we go back to the definition of alienation "a problematic separation between a self and other that properly belong together" (SEP, 2018), in terms of the healthcare workforce, we can imagine how a problematic separation might exist between care providers (the self) and the caring work they do (for the patient). Care work is a vital aspect of nursing, medicine, pharmacology, and paramedicine, to name a few, and this work often requires a degree of emotional labour. For critical care providers, their emotional expenditure can be massive, sometimes far outweighing the technical aspects of caregiving.

From my perspective, the more we commodify emotional labour, the less we seem to realise its costs. Marx's idea of alienation, which was further applied by Hochschild, has greatly helped me to orient my own lived experience. My experience has been that caregivers seem to have lost an integral connection to their work, the part that is satisfying to them, that is, the emotional repayment that comes from the satisfaction of giving good care, seeing patients return to health, and receiving both esteem and praise for this work. The reasons for this seem to be intricately linked to the ways in which medical institutions focus heavily on technologizing care, medical specialisation and silos, as well as the oppressive socialisation that caregivers are put through, conditions which require healthcare providers to suppress their emotions, produce an appropriately caring disposition (or the illusion of it), or ignore their intuition.

This fact warrants further concern if we consider what might happen if providers become estranged from their ability to act effectively as caregivers, such as the pressures Covid-19 put on global institutions, increasing burnout worldwide. Seemingly, when there is enough of a separation between provider and patient, during Covid-19 this included physical glass walls in ICU as well as personal protective equipment (PPE), there is less satisfaction on both ends (this takes us back to the literature on empathy, see Chapter 5.4). We can imagine caregivers thinking, "What's the point? My patient dies anyways and feels uncared for," and patients feeling as though they have been forgotten or are unimportant. This degree of decreased satisfaction affects both the quality of the care work given and the engagement of the provider, leading to a lessened desire of the caregiver to continue in the caregiving role. It is plausible that caregiving institutions, like hospitals, may see their employees suffer burnout and other mental health issues to a greater extent than other occupations, due to dangerous levels of alienation from the self, others, and the work being delivered.

After analysing my qualitative data, the driving forces that contributed to alienation centered around (1) the physical separation of the caregiver and the patient (e.g., through care work that is abstracted from physical patient interaction, such as patient charting, or through emotional distance created by machines and a lack of personal time with patients); (2) how caregiving has become more and more complex in the twenty first century, as continuous developments of medical technologies (e.g., electronic medical record or EMR), interventions (ECMO), and pharmaceuticals emerge (Covid-vaccines), many of which have improved community health, but have simultaneously complicated caregiving (e.g., infusion pumps, dialysis machines, robotic surgeries, bypass machines); (3) what feels like a disengaged administration and institution that superficially promotes wellbeing, yet, fails to deliver support and resources when they are needed most; and lastly (4) a system of cultural beliefs and practices that are antiquated and adhere to principles that are no longer appropriate, such as those that are not in-line with equity, diversity, inclusion, and accessibility (EDIA), or beliefs that are limiting: recall William Osler's famous "Aequanimitas" address.

> It is so easy to see the patient as a bionic entity that is made up of a fleshy core, the body itself, which sits in the center suspended by metal wheels and a cushioned platform which can move in all directions, their electric veins and arteries spider web out, and every orifice connects to the various aspects of their artificial self, all of which are pumping, moving, breathing, and calculating. The respirator sighs in and out, the vitals monitor beeps, and the dialysis machine hums. They exist now as a series of values, numbers, sights, smells, and sounds… but when you get close enough, and if their eyes open, you can see them finally.

The psychosocial influences that I have spent many chapters outlining also come into play and contribute to alienating forces. If we consider the culture of inclusion in the ICU, some team members may have an attitude that everyone should be equally included in care conversations in the ICU, whereas other members of the team may purposefully exclude specific members of the team due to conscious or subconscious beliefs (e.g., that person doesn't need to know, they are just an RT; I don't like dealing with that person, let's decide without them). The social culture of medicine can affect everything from the treatment of staff to the proper or fair distribution of physical resources. Situations that are unjust, demeaning, or purposely malicious can be alienating, but they are also reflective of the types of relationships that exist which are historical. In my data, it was clear that simple historical social factors (e.g., one ICU does not like another ICU down the street) can influence access to necessary items, and thus readily affect care. As previously discussed, there is a 'protect your own' mentality within siloed medical units (arguably, an alienating feature of structure and design).

> I picked up the phone, quickly saying "Hello, OR Hillary speaking." The person replied, "Hi, yes, I am calling from the OR down the street, we need to borrow a trach set, do you guys have one you can lend us?" "Let me put you on hold for a minute, okay?" I said as I pressed the hold button and looked over at the charge nurse. The charge nurse smiled knowingly and said, "Yes, what do they want this time?" "They want to borrow a trach set from us, is that okay, do we need it?" I asked. The charge nurse paused and then sighed, "Well, we need at least one here for emergencies, and we currently have a tracheostomy on the waitlist… why don't they have their own?" It was silent for a minute, until they finally said, "Okay fine… tell them this is the last time, they need to get their own! We need ours." "Thank you!" I said as I picked up the phone to call the OR back.

Being stuck in a position without the right equipment can majorly affect care environments, this can risk patient safety and can cause a lot of stress for caregivers.

> I picked up the phone, “OR Hillary speaking,” I said. “Hi, it’s emerg, we have a patient with a stab wound to the chest down here, and we will be coming any minute!” The person on the other end replied. “Oh my, okay, one second,” I said, “Let me just get some information and find the charge nurse...” I had just put them on hold as the second line began to ring, “Hello, OR, Hillary speaking,” I chimed again, “Yes, this is emerg, we have a patient who needs to come pretty urgently to the OR, she has a significant GI bleed,” they replied. “Okay, let me put you on hold,” I said, while I looked around for the charge nurse again. “Dave!” I shouted out into the inner core, “We have two people on the line from emerg,” He interrupted me to say, “Oh, yes I heard we might have a gunshot wound coming soon.” “What!” I exclaimed, I told him, “I already have two patients that emerg is saying are level-1 (*this means the patient must come to the OR stat, i.e., now*), and neither of them have had a Covid swab.” “Shit,” said Dave. He knew we couldn’t wait for a Covid test result, meaning, we would have to set the rooms up with precautions, full gowns, gloves, restricted access, everything. Covid rooms required even more staff, as some needed to be runners (people to stay outside the OR and grab equipment and material), “Well,” he said, “We need to get some on-call people here ASAP, and find out how we can set up two Covid rooms with only one Covid cart, and run three rooms with two anesthesiologists...” I stared at him in disbelief and then started making phone calls.

Events like the ones described above occur frequently in the hospitals where I have worked. Throughout the years I have noticed that the repetition of these events contributes to staff disillusionment, as these problems never seem to go away. The phrase “nothing changes around here” was very common. You can imagine having a very stressful shift where you did not have the right equipment and you had multiple emergencies (patients who need emergent services) requiring your full attention, only to experience *Groundhog Day*[42] the next night, where you repeat these events (or ones very similar). After a while, you would start to wonder if there was a better way to approach this recurring problem. In situations like this, systemic change may be required, or in some cases, the problem is not so easily solved if there are many moving parts to the equation.

What is important to note here is that the repetition of stressful circumstances will contribute to alienation, as caregivers become disillusioned that a solution will be provided to them, and in

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[42] A film from 1993, which according to the summary of the movie on IMDb, is the story of “A narcissistic, self-centered weatherman finds himself in a time loop on Groundhog Day” (Rubin & Ramis).

response to this, they begin to withdraw and protect themselves from the stress these events cause. Caregivers will become less open and less willing to give of themselves in these situations, which can also breed apathy. The first time, the caregiver may have been fully invested in solving the problem, protecting the patient, and finding ways to protect their colleagues; however, after the same occurrence continues to take place time and time again, it becomes clear that it is better and safer to withdraw their emotional investment in the situation, ignore the deeply problematic aspects of the situation, and accept that there is nothing they can do. Their apathy is not freely chosen, instead, it is forced since the caregiver's emotional resources have been depleted over time. They are also forced to downgrade the quality of their care and their investment in a situation that traditionally mattered very much to them. This compromises one's integrity and alienates them from the work.

The results of alienation mean caregivers have fewer opportunities to use their skills effectively and to experience the benefits of giving good bedside care because the system has made it impossible for them to shine and share what they have to give. Kelly Stanton, a nurse in Washington who left her role during the Covid pandemic, says "you do it because you care, you want to help people... But right now, nurses don't feel like heroes. We feel expendable" (Ali, 2020). She refers to being compared to soldiers during a war, as the public response was "as a nurse, you signed up for this" (Ali, 2020). She replies to this statement by saying that we would not send soldiers to war without a gun, and I would argue that we do send nurses to the bedside without proper support. The soldier analogy used by Stanton here is a good one, and it reminds me of a classic example of nursing care during the Crimean War in 1853 when Florence Nightingale carried her lamp through the hallways of the hospital base in Constantinople.

At this time, during the Crimean War, "The soldiers were poorly cared for, medicines and other essentials were in short supply, hygiene was neglected, and infections were rampant. Nightingale found there was no clean linen; the clothes of the soldiers were swarming with bugs, lice, and fleas; the floors, walls, and ceilings were filthy; and rats were hiding under the beds" (Fee & Garofalo, 2010, p. 1591). Nightingale formed the fundamental tenets of contemporary nursing at a time when nurses were still considered to be uneducated, their profession lowly, and their skills un-honed. During the war, Nightingale rallied nursing troops to clean patients, remove them from unsanitary conditions (i.e., urine, excrement, and pesky vermin) and sought to bring patients more sunlight, clean bedding, routine health assessments, and humane connections. Her basic understanding of the key elements behind health and happiness was timeless and gained through her first-hand experience.

By cataloguing what she saw in the field, her work revealed that "nearly seven times as many British soldiers had died of disease than in combat," pointing to hygiene and sanitization as being more important than the horrible effects of war. She recognized the healing capabilities of cleanliness and a proper environment. Today, hospitals aim for sterility and cleanliness, and are well tended in the 21st century; although, it is easy to forget how simpler actions can be healing because they seem too obvious and are profoundly basic. Nightingale believed that heavy curtains should be dusted and opened wide so that sunlight might pour into patient rooms, and patients should face towards the window where they can better envision their life outside of the white hospital walls. She believed that some foods were healing, and others were inflammatory; that patients should be warm or cold depending on their circumstances, and always observed carefully (Nightingale, 1869/1969, p. 84-85). Her attention was on the small details, the feeling you had when you walked into a room, the presence or absence of items and people, and the meaning behind them.

Can a comparison be drawn here against Nightingale's brilliant move during the war to shift our thinking away from tending to battle wounds alone and towards the simplicity of meeting basic human needs such as hygiene and being able to see the sun? I would argue that some of the alienation caregivers experience is rooted in the absence of some of the things that Nightingale felt were of supreme importance during her time, items that have been replaced by technology and systems, or have been neglected altogether. Key to her *Notes on Nursing* were good management; the collective design and building of healthcare institutions that include healthcare administrators *and* nurses; the importance of the patient's physical environment (e.g., good ventilation and asepsis); the importance of observing the patient by looking at all the conditions in which the patient lives (family, relationships, etc.); the focus on a single patient, as unique; the importance of psychology and concern for the patient's emotional state; and monitoring how family and friends affect the patients wellbeing; all of which summarises her focus on the "handicraft" of nursing (Nightingale, 1869/1969, p. 127).

To Nightingale, a nurse must use their intuition, carefully observe their surroundings, and be empowered to make choices. She cautions against reading her notes as a recipe for nursing, she argues that she cannot teach one to be a nurse, only inspire and share her experience. She cleverly writes "let no one think that because sanitary nursing is the subject of these notes, therefore, what may be called the handicraft of nursing is to be undervalued. A patient may be left to bleed to death in a sanitary palace. Another who cannot move himself may die of bedsores because the nurse does not know how to change and clean him, while he has every requisite of air, light, and quiet" (Nightingale, 1869/1969, p. 127). If we think these things are important for patients, why would we not see them as important for caregivers? Caregivers also need fresh air, light, sleep, sanitary conditions, and especially psychological and emotional care.

In this chapter I have summarised the ways that caregivers quietly tend to their emotions or conceal them from patients and fellow providers; I have discussed resilience, a topic that is debated in medicine, but it is thought to be one way of resisting or recovering from occupational stress; I engaged in a discussion on empathy and considered the belief that empathy is emotionally draining, or if in fact, empathy can be a protective factor that staves off medical burnout; I outlined Powers and Myers concept of emotional labour and Arlie Hochschild's framework for feelings rules and emotional management techniques, which contribute to emotional exhaustion; lastly, I provided a quick overview of potential features of hospitals and care work that are alienating, particularly within a system of care provision that has been commodified.

In the next chapter, we will explore the field of 'care ethics' or 'an ethic of care', which is a moral and political theory that considers the basis of moral action and moral decision-making to be relationships and advocates for caring motivations, caring actions, and relational responsibility. The purpose of this chapter is to engage with the last theme identified in the data, that of 'care,' which is central to caregiving and care receiving. The arguments made in this project are political in that I am stressing a call to action, whereby institutions have an ethical obligation to address the moral, mental, physical, and psychosocial suffering of caregivers in Canadian hospitals, particularly in critical care departments. Thus, this next chapter also engages with some of the problematic political factors that contribute to caregiver abuse and neglect.

Chapter Six

Care Ethics

6.1 Who Cares and What Matters?

Early in the Covid-19 pandemic, many were privy to videos, news broadcasts, articles, and first-hand accounts depicting the outcries, discontentment, and tears of healthcare workers. This pandemic provoked a shared sense of global upset towards the neglect of caring institutions. This fact was made very public by caregivers/caretakers around the world who lobbied for aid from the government, health administrators, the general public, and scientists to assist them in facing the deadliest respiratory illness known to strike the developed world since the Spanish Flu (1918 Influenza pandemic) (Taubenberger & Morens, 2006). There are many ways to respond to the sight of media portrayals of healthcare workers suffering, one of which is: to show *care*. This may sound like an obvious statement – that we ought to care about the healthcare workers who are struggling to provide care for patients – however, I argue that such a response (i.e., to show care) is not always the default reaction.

To quote the recently published *Care Manifesto: The Politics of Interdependence,* put forth by the Care Collective in 2020, "Our world is one in which carelessness reigns…the coronavirus pandemic merely highlights this ongoing carelessness" (Chatzidakis, et al., p. 10). At a large scale, uncaring practices seem to be everywhere we look if we stop to consider widespread instances of racism and intolerance, sexism, and misogyny, acts of terrorism, abuse of animals and the environment, gun violence, and not to mention extremely high levels of depression and anxiety worldwide. Feeling uncared for, for many of us, has become a way of life. Being uncaring includes everything from having a critical internal voice (e.g., saying to yourself "I am so stupid, why did I do that?"), choosing harmful words and statements to say to others (e.g., telling your friend "I hate that outfit, it makes you look fat"), to the actions we take in the world (e.g., choosing to exclude someone based on how they look, or throwing your garbage out the car window). Everything we think, say, and do will have consequences such as the various negative effects our uncaring ways have on the world.

If you are a caring person, your first response to the above statement might be to think "Well, I *do* care," meaning, you either feel offended by the statement that our world is dominated by carelessness, or you may feel that you stand as an exception to this rule. I am going to be bold in my argument in this chapter and state that few of us care as much as we ought to, and we all stand to care more than we already do. Understanding the nuances involved with having a caring *disposition* or completing caring *action* is vital in a time where pandemics, terrorism, war, and intolerance still occupy much of our focus. The 2022 *Freedom Convoy*[43] of protesting truckers who converged upon downtown Ottawa (with many joining supporters), and the Supreme Court decision to overturn *Roe vs. Wade* in the United States (ending a woman's constitutional right to abortion), and the globally polarised issue of climate change, are all demonstrative of how divided people are on their opinions about what the right thing to do is, given their respective values.

Not everyone agrees on what the right course of action is in any given situation, and ideas that may seem straightforward in our hearts, like freedom or the right to choose, can be used to defend actions that we may not agree with or condone. Nel Noddings makes this point when she says that "wherever there is a principle, there is implied its exception and, too often, principles function to separate us from each other" (1984, p. 5). Some individuals felt that the Freedom Convoy represented liberation from tyrannical political control through the lifting of Covid-mandates, whereas others felt that a lifting of mandates would put people's health at risk, giving defenders of Covid mandates a sense that their freedoms were being infringed upon by those who felt mandates were unnecessary. In either case, you may feel disrespected, or that the opposing group members do not care about you or your values. This is also a cornerstone of moral distress since situations like these can contribute to the horrible feeling we get when we think we know what the right course of action is, but we are prevented from executing it. In medicine, if you repeatedly feel this way, this can lead to moral injury over time.

Uncaring practices can be insidious and nuanced, especially when they have become a habit. The effects of being uncaring ripple both outwards and inwards, out into the world to affect people's lives and feelings, as well as to degrade our own self-confidence, self-image, and self-respect. Thus, the consequences of uncaring attitudes can be extensive and can produce lasting damage, even anxiety disorders and post-traumatic stress. Individuals who are not properly cared for will experience physical, emotional, and even psychological effects. Again, the impetus to be uncaring is not always a choice. Rather than imagining that any act of harm has an evil or corrupt origin, due to a bad seed or a lack of conscience, we should instead imagine that most uncaring reflexes are a symptom of the perpetrator having not been properly cared for themselves or they were not taught to behave in a caring way. In other words, people who are loved and accepted in this world, as well as those who have been taught the value and method of how to be caring are more likely to avoid the pitfalls of harmful thoughts, words, and actions towards others. This makes caring a pedagogical concern.

This chapter will be dedicated to unpacking the complex ways in which care operates, how we all fail to care at certain points in our lives, how we often fail to understand when care is needed, and

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[43] The Freedom Convoy refers to an occupation movement in Ottawa, Canada, where far-right truckers and supporters stormed the capital and refused to leave, "disrupting traffic, entering buildings maskless, honking horns late into the night and harassing the city's residents" (Preston, 2022). This protest started in response to a government mandate to have all truckers who cross borders be fully vaccinated for Covid-19, although the movement escalated and became a general lobby for the protection of "rights and freedoms" (Preston, 2022).

further, how we may fail to care well. This chapter relies more heavily on the literature; however, this literature base was chosen purposefully for this conversation, because these researchers have captured the same spirit of what I was seeing in my own autoethnographic data when it became clear the caregivers in my institution were not being adequately cared for (see examples in Appendices 1 & 2). I argue, in keeping with other scholars of care ethics, that major political and social structures do prevent us from learning how to do better, but there are still ways in which individuals can seek to overcome boundaries to caretaking, and in the long run, we can all work together to dismantle larger uncaring forces.

The *Care Manifesto* is only one collection of voices aimed at helping us to gain more awareness about the blind spots we all share (Chatzidakis, et al., 2020). Convoys, Covid-19, war, and climate change mark the global state of things, as governments have put forward a lot of caring words, but few actions have truly aligned with what is best for people. The Care Collective writes that:

> "[C]ountries dismissed early warnings about the very real and imminent threat of pandemics to come, choosing instead to waste billions on military hardware against distant or non-existent threats and to funnel money to the already rich. This has meant those most at risk from Covid-19 – health workers, social carers, the elderly, those with underlying health conditions, the poor, the incarcerated, and the precariously employed – have received negligible help or support, while lessons that could have been shared on the best ways for protecting them have been largely ignored" (Chatzidakis, et al., 2020, p. 10).

The large-scale ability of countries to ignore, and for people to be unaware of such rampant need (or be apathetic to it) are features of such carelessness. Carelessness is also perpetuated by power/powerlessness and by structures and attitudes that continue to marginalise individuals and their caring work.

This chapter discusses whether there exists a moral obligation for each of us to prioritise the care of others, and how we might achieve such a goal; one such response would be to employ the teachings of *care ethics,* a philosophy centred around the moral requirements for caring well. Certainly, the idea that humans are caring beings who value activities special to care is present within much of human history. Milton Mayeroff's book entitled *On Caring* (1971) is a short discussion about the different aspects vital to caring for oneself and others. He writes that "to care for another person, in the most significant sense, is to help him grow and actualize himself" (1971, p. 1). Mayeroff feels that care extends far beyond our ideas of "wishing well, liking, comforting and maintaining, or simply having an interest in what happens to another," instead, true caring is a process (1971, p. 1).

The emergence of a concrete moral theory around care is most attributed to two prominent authors of the 1980s, including Carol Gilligan who published *In a Different Voice: Psychological Theory and Women's Development* (1982), and Nel Noddings who released *Caring: A Feminine*

Approach to Ethics and Moral Education (1984) (Sander-Staudt, 2022). Gilligan worked with Lawrence Kohlberg (a famous developmental psychologist) and in so doing found her own intellectual niche through the act of witnessing his blind spots. Kohlberg mostly used young boys to study child development, restricting his understanding of individuals to the male perspective. Since women and girls were excluded from much of his research, Gilligan's own work sought to ask women how *they* felt about certain topics. When listening to the responses given by these women Gilligan revealed what she referred to as a "marked difference of voice." This *difference of voice* was understood by Gilligan to be somewhere between the male's tendency to talk in terms of autonomy and justice and the female tendency to view situations as interconnected and relational (Gilligan, 1982). She has since clarified her view in her 2023 book *In a Human Voice*. In the following excerpt, Gilligan writes:

> "Recently I was asked to talk about my experience in writing In a Different Voice. Going over what for me was familiar ground, I was surprised to arrive at an insight about something that had been confusing me for many years. It occurred to me that I had inadvertently built a tension into the title of both my initial essay, ... I had joined an exploration of difference (a different voice – different from what?) with the subject of women, thus setting myself up for a trap that it has taken me years to extricate myself from: Are women different? Are women different from men? Do women make a difference? Am I an essentialist? Do I know that all women are not the same? Do I know that race and class matter as much as or even more than sex or gender? And so on. Ironically, my work came to be viewed through the lens of the very binary comparisons and hierarchies that I had set out to challenge" (p. 107).

Noddings makes a similar move, to Gilligan's original work, away from the ideas of justice and ethical principles and toward sentiments of care and caring. Her discussion is extensive, as she covers a lot of ground between humans, "animals, plants, things, and ideas," but her central focus is on a feminine approach to ethical matters which is thought to be expressive and relational. Her arguments are not put in "the language of the father" she writes, or what we understand to be the more masculine principles of logic and reason (1984, p. 1). The heart of her ethics is inherent in the "caring attitude," a position that she argues is rooted in "*joy* as a basic human affect" (1984, p. 5-6). She proposes ways in which her caring ideals can be instilled in educational efforts, a moral engagement that seeks to tutor all who want to understand how to care for others, as well as how to sustain that care.

Following in this tradition (appearing ten years after Noddings' publication) is the work of Joan Tronto, a political and moral philosopher who argues with Bernice Fisher that care pervades much of human activity. Even though care is a central feature of our existence, they argue that this fact is often ignored by those in power (1993, p. 111). Tronto's work is naturally derived from many of the same arguments that Noddings makes, although she pushes these ideas further, most notably, into the political realm. Noddings writes in the introduction of her book that the specific suggestions she makes are "not intended as fully developed plans for action but, rather, as illustrations of an approach, of a mode of thinking and feeling about education" (1984, p. 6).

In contrast to Noddings' gentle "invitation to dialogue," Tronto asks the reader more pointedly and seriously why we do not acknowledge the extent to which care is such an important aspect of life, and therefore, why no mention of its necessity enters the political spheres where decisions being made affect everyone (1984, p. 6). Tronto's ideas and her arguments are central to my own, but we cannot ignore the contributions made by Mayeroff, Gilligan, and Noddings that came before her, which have surely helped to shape her own thoughts and feelings about care activities.

6.2 Tronto's Ethics of Care

The word *care* is ubiquitous in society. Joan Tronto says that "care is a common word deeply embedded in our everyday language" (1993, p. 102). What is even more profoundly entrenched than the use of the word care in speech is the *practice* of care in society. Despite the common nature of care, Tronto makes the crucial point that "we do not pay systematic attention to this dynamic of life" (1993, p. 111). Tronto means a variety of things by this, all of which will be dealt with in this chapter, but simply put, she feels that people (typically those who are privileged) can choose to ignore (in different ways) many of the fundamental aspects of care as both a concept and as a practice. This will lead these individuals to care badly, whether on purpose or not.

Tronto argues that since care – as a subject of normal political life – is not acknowledged to the same degree in which care actually occurs as an activity amongst beings (Tronto, 1993), care activities and practices related to care can more easily be dismissed. This argument is put forth in her book *Moral Boundaries: A Political Argument for an Ethic of Care*, where she says that "care consumes a large part of our daily lives" but is "treated as so marginal a part of existence" (1993, p. 111). For Tronto, citizens regard care to be a weakness, as something that should be hidden and done in private, and due to its lack of value – it is often designated to be completed by marginalised individuals (Tronto, 1993).

Most of us know what the word 'care' means, and we certainly all have our own personal interpretation of what we think it should mean. Yet, we may also take for granted the complexity of the concept of care, and the degree to which acts of care occupy our time. Before we engage with conceptions of care, it will also be important to note the intersecting expectations that are put on caregivers in hospitals who engage in *work* practices within their organisational lives (which is paid labour), however, the work they do is to provide *care-giving*. Critical care providers also have very intense caregiving responsibilities. Thus, I would like to note here that there are various differences between 'work' and 'care,' especially when we compare and contrast unpaid care (e.g., care that is given freely in the home by a parent) with the care that is paid for (e.g., by a VON[44] nurse that comes to a person's home).

Jennifer Jackson (2022) explains that "nursing work has historically been difficult to specify, as it has numerous unrecognised aspects," since "nurses may be distinguished through their caring role, but focussing on care tasks alone does not fully capture nursing work or recognise the role of healthcare environments in supporting nurses' ability to provide care" (p. 504). In other words, nurses occupy many different types of roles in their work, which range from clinical all the way to general management of the unit. Jackson's review "showed that nursing work includes cognitive, physical, emotional and organisational labour, all of which create a complex series of activities that cannot be understood using a reductionist focus on tasks," and that "these domains of labour illustrate many aspects of nurses' work that are not immediately visible (such as a nurse's thoughts) and may be difficult to recognise" (p. 505). One of the nurses in their study was quoted as saying:

> "If you were bed bathing a patient, you're not just actually washing that patient and looking at the skin, you're obviously using that opportunity to have some conversation with them, depending on how they are, so that you're actually building emotional support and assessment into the everyday tasks that you're doing (P3. nurse educator, adult nursing)" (Jackson, 2022, p. 508).

Caregiving activities have also changed substantially over the years, since patients have become more comorbid, new diseases have been discovered or have emerged, as well, technology has widened the options caregivers have to provide patients with. These factors have undoubtedly changed the landscape of care work and caregiving activities.

> "The complexity of patients is just huge, it's really increased even in this short space of time since I've started working in community. It's a huge difference. And some of the care that we give is care that years ago I never would have thought we'd be giving, so it's really changed unrecognisably in the last sort of five years or so (P13. adult nursing, district nurse)" (Jackson, 2022, p. 512).

Caregiving roles also intersect when nurses are also parents, who must care for patients during the day and then come home to care for their children, as well, they intersect in a more abstract way, if we imagine the similarities between care work in a hospital and caregiving at home, these activities may be very similar – which may very well require the same resources from an individual no matter what

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[44] VON stands for the Victoria Order of Nurses in Canada who provide nursing care. "Our nurses, personal support workers, therapists and other health-care providers deliver care and services that offer clinical, personal and social support in homes and communities across Nova Scotia and Ontario" (VON, 2022). VON commonly provides nursing care within the homes of patients who are able to receive care outside of the hospital, but still require specialist support.

environment they are in. For instance, when you are trying to calm your crying four-year-old this may feel similar to needing to calm down your patient who is anxious about their upcoming surgery if you need to call upon the same caring resources (e.g., patience, calm demeanor, or positive thinking), whereby one utilises the same emotional strategies within oneself. In this chapter we will be talking very specifically about care work, caregiving, and work that is either caring or non-caring, and the ways in which our beliefs affect care, either through our gendered expectations, our political boundaries, or the level of knowledge about how to care for people.

On a cursory consideration of care, you might feel that this term covers a large general territory including everything from taking an interest in something, such as when someone says "I care to learn more about the process of making a perfect Italian meringue," all the way to being deeply engaged in the guttural feeling of care, e.g., when looking into the eyes of your new-born baby and feeling an indescribable sense of love and devotion. We also engage in caring activities more frequently than we might notice. This includes daily self-care practices, such as showering, plucking eyebrows, shaving beards, and working out. We engage in care for our families, friends, and communities by taking our children to ballet lessons, helping our grandparents mow their lawns, bringing casseroles to our neighbours, volunteering at shelters, or supporting community projects. Furthermore, some like to engage in activities (even seek out careers) that help care for the world or to promote justice, safety, and wellbeing for all. Teachers, firefighters, and nurses are classic examples of caring occupations, but many others support the good of everyone, including counsellors, custodial workers, and activists. Larger-scale caring activities include reducing our levels of environmental waste, cleaning up oil spills, advocating for less cruelty to animals, and planting trees.

Tronto argues that care "connotes some kind of engagement" (1993, p. 102), but not just any type of engagement. For her, caring engagement with others must meet a particular standard or threshold, the sufficiency of which is determined by "how well integrated the process of caring is" (1993, p. 110). We can begin to understand the limits of 'care' using Tronto's own example, saying "I don't care," since determining what care entails is perhaps made clearer by its negation (1993, p. 102). She uses this phrase to demonstrate that by saying "I don't care" you are saying something very different from "I'm not interested in that" (1993, p. 102). For Tronto, being interested or disinterested, caring or not caring, are different things. This is because, as she says, the word care "seems to carry with it two additional aspects" (1993, p. 102). The first aspect is that "care implies reaching out to something other than the self," she says that "it is neither self-referring nor self-absorbing," and second, that "care implicitly suggests that it will lead to some type of action," in other words, it is the "acceptance of some form of burden" (1993, p. 102-103). Care then involves the acknowledgement of a *need* from something outside of the self, and it further requires a sense of obligation that is felt towards addressing such a need through action.

The "ideal" version of care, or what she refers to as "care as a standard" (not to be confused with the medical notion of a *standard of care*), may rarely be met, given its strict criterion; however, generating an ideal notion of care is nonetheless a necessary guideline for determining whether or not "care is being well provided" (1993, p. 110). As we will see below, care that has been "well provided" meets four distinct criteria. Tronto takes the time to systematically "delineate the meaning of care" (1993, p. 102) by breaking it down into what she calls the *Four Phases of Caring* (1993, p. 105). But before we get into the heart of the four phases, I want to first say a little bit more about care (in general) as it is understood to operate by Tronto and Fisher.

For Tronto and Fisher, care is species-specific, but it is not limited to interaction with humans alone. Care is an activity that operates as a *way of being* as well as a way of teaching, but not simply between mothers and their children or a husband and wife; it can extend to larger and more complex webs of caring relationships, and it can even extend to inanimate objects, animals, or the environment (1993, p. 103). Tronto and Fisher agree that the concept of care "is largely defined culturally, and will vary among different cultures" (1993, p. 103). They propose that care is "ongoing" in that the activities related to care can mark a single instance of caring, or care may "describe a process" (1993, p. 103), making care extend quite broadly into human life. Lastly, care is "both a practice and a disposition," helping to narrow the concept (1993, p. 103).

Tronto writes "I will use care in a more restricted sense, to refer to care when both the activity and the disposition of care are present" (1993, p. 105). This marks the difference between caring about climate change intellectually and caring about climate change enough to act to reduce one's own carbon emissions and waste (1993, p. 103). Lastly, even though Tronto's argument seems to suggest that 'care' involves almost everything we do, she writes that "not all human activity is care...[since] to play, to fulfil a desire, to market a new product, or to create a work of art, is not care" (1993, p. 104). To summarise these ideas Tronto and Fisher present a definition of care, which goes as follows:

> "Care is a specific activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, ourselves, and our environment, all of which we seek to interweave in a complex, life-sustaining web" (Fisher & Tronto, quoted in Tronto, 1993, p. 103).

The above definition broadly encapsulates the variety of individuals involved in caring processes and the objects, subjects, beings, or environments that receive that care. This definition allows for an open-ended mission statement: "so that we can live in [the world] as well as possible" (1993, p. 103). How "well" we want to live in our world is a subjective claim, since it is value-based, but the definition is inclusive if we take the term "we" to refer to everyone. Their definition is also generated towards action, in that it references "everything that we *do*" or seek to do together to care.

This idea is representative of Tronto's requirement for a caring disposition *and* action. Lastly, their definition is somewhat directional as it is rooted in the value that our actions and intentions be "life-sustaining," in other words, the ways in which we care for others should help to promote – in complex ways – the lives of all; presumably where death is an integral and natural part of that process.

6.3 Four Phases of Caring

Tronto and Fisher offer four *phases* of care, which can be understood both as choices and as processes, which will be summarised here. The four phases of care are: (1) *Caring about* (or attentiveness) which involves the acknowledgement or perception that care is required – this might include listening to another articulate their needs to distinguish what type of care is called for; (2) *Taking care of* (or responsibility) is when an individual takes on the duty to meet the identified need or assumes responsibility in a serious manner (because it is not enough to simply see that needs exist); (3) *Caregiving* (or competence) which is when care provision finally takes place, this involves "knowledge about how to care," and how to care well; lastly, (4) *Care receiving* (or responsiveness) is when those who are receiving care can identify whether or not their needs have been met accordingly, in other words, "whether caregiving was successful" (1993, p. 105-108). Using the four phases of care, Tronto and Fisher have provided a framework by which we can judge "good caring," although they do recognize that caring relationships will never be perfect or ideal.

The four phases of caring represent the core of Tronto's argument for an ethic of care, although her book goes into much greater detail, outlining the complicated ways that power relations and structural forces function to govern care, and the different types of conflicts that are involved in caregiving and receiving. Her "ethic of care" is a moral call to action – since "to be a morally good person requires, among other things, that a person strives to meet the demands of caring that present themselves in his or her life" (1993, p. 126). Tronto writes that "ideally there is a smooth interconnection between caring about, taking care of, caregiving, and care receiving" although, "in reality, there is likely to be conflict within each of these phases, and between them" (1993, p. 109).

To illustrate this conflict, she uses an example that is highly relevant for our purposes here, as it draws on the tensions inherent to the nursing role. She says, "nurses may have their own ideas about patients' needs; indeed, they may 'care about' a patient more than the attending physician," although decisions about how best to care for patients may be beyond their scope of practice (Tronto, 1993, p. 109). Despite being responsible for most of the active caregiving to patients, the role of "taking care of" may be designated primarily to physicians. The nurse may notice something that seems significant, but often the ultimate power of decision-making lies with the patient, their family, the overseeing doctors, and higher levels of authority. Tronto appropriately acknowledges how "often in bureaucracies those who determine how needs will be met are far away from the actual care-giving and receiving, and they may well not provide very good care as a result" (1993, p. 109).

6.4 Feminist Contributions

Care – for Tronto – is a basic function of human life, and the nature of care is an ethical concept. She reminds us that the origin and meaning of the word *ethics* was "knowledge about how to live a good life" (Tronto, 1998, p. 16). Our understanding of how to live a good life often requires us to know how to care for ourselves, for others, and for the world around us. Humans are relational beings, so we do not thrive in isolation. We also tend to overestimate our ability to succeed as autonomous individuals. The accentuation of autonomy in ethics and medicine over time has been a strong push away from the paternalistic tendencies of the past, away from control and towards self-governance and freedom of choice (Beauchamp & Childress, 2009). Although principles do help us to preserve justice and allow for more social freedom, ideas such as autonomy, and "strong independence" simultaneously put forward the sentiment that "upward social mobility" or personal well-being and success is gained through hard work and determination by the individual *alone* (Gilbert, 2017). The ethos of neoliberalism supports equality (or equal opportunity), but it does not support equity for all. Nor does it speak to the complex ways in which we are relational beings who are often reliant upon help from others to ensure our own well-being.

Emma Dowling, author of *The Care Crisis*, also reminds us that "an effective care infrastructure cannot be built on personal responsibility" alone, because "not everyone is able to care for themselves" (2021, p. 195). Even for those who can care for themselves and others, the degree to which "autonomous" individuals are able to move up or down their respective income or social ladders is still dependent upon race, sex, education, parental status, and community involvement (Gilbert, 2017). Tronto writes that "citizens are not equal by virtue of being declared equal, but through an elaborate social process through which they become equal" (Barnes, et al., 2015, p. 11). She also writes that "it is quite remarkable that this image of the breadwinning, autonomous adult male so dominates the way that we conceive of citizens because it so obviously does not describe how any humans are for all of their lives" (Tronto, 2010, p. 163). These messages tend to instil the belief that the best way anyone can contribute to their own lives (and that of others) is to leave the home to retain employment, i.e., to do something more valuable than menial care activities; yet these care activities must then be absorbed by others around us through "the help," institutions (i.e., day-care), or loved ones (often women).

Dowling also reminds us of movements that sought to "de-gender the social division of labour," as she cites the "Wages for Housework" campaign held by the *International Feminist Collective* in 1970s United Kingdom (2021, p. 199). This political feminist movement lobbied to acknowledge the reproductive and social contributions of women who have traditionally performed most of the domestic work without compensation. Louise Toupin (n.d.) writes that "the vast majority of women who had waged jobs returned to being houseworkers once they got home, having worked during the day in specialised sectors associated with housework. It turned out that waged and unwaged women were, in reality, the same people" (para. 2).

But not everyone who performed these tasks were women, thus their slogan was inclusive and intersectional in that it regarded anyone doing domestic caring work to be entitled to wages for house-*work*, not only house-wives (Toupin, 1972). This campaign "offers a historical backdrop for many of today's debates," including care work (Toupin, 1972). *Wages for Housework* advocates remind us how political frameworks like capitalism, or the values instilled in wage-based societies, can oppress those working hard to sustain them, but who may fail to benefit from the fruits of this labour (labour that they are needlessly alienated from). Women, who often do much of the reproductive work, literally create the labourers that populate the workforce, but this aspect of work is not conceived of as compensatory, it is just expected. Such mechanisms contribute to how we view and operationalize care.

The phenomenon of dividing caring roles by their value further enforces our lack of regard for hands-on caregiving work. Physicians have moved away from doing the caring work that is less pleasant, and towards caring work that is viewed as more worthy of their time and effort, or special to their status (e.g., conducting rounds or doing research). Nurses spend most of their day interacting directly with the patient and family, moving them, feeding them, and helping them go to the bathroom. This type of care is arguably essential to all patients, yet it is viewed as needing to be done in private and unacknowledged as vital work, both for the patient's privacy, but also because they are uncomfortable practices that we hide away. Both divisions of care and labour have very important effects on the patient, although these caring actions are valued and compensated for in different ways.

A key feature of Tronto's argument, one that is also shared by Arlie Hochschild, is her distinction between how care is viewed in *private* and in *public* (Tronto, 1998). As noted above, care has traditionally taken place within the privacy of one's home, often performed by the women of the household. Due to gender inequality and negative biases towards women, female contributions of care are frequently undervalued, e.g., making dinner is thought to be "women's work," or considered essential to female existence, e.g., "doing housework was [thought to be] an integral part of the 'nature' of women" (Toupin, 1972). Thus, she is also preoccupied with the various ways that "care is contained" (within "work" that is "gendered, raced, classed" or viewed as "a weakness") and the conflicts that arise in caring transactions (1993, p.112-122). Kate Manne writes in her book *Down Girl: The Logic of Misogyny* that there is a "gendered economy of moral and social labour" whereby women are expected to produce more than their fair share of caring work, which might also be called "feminine-coded work" (2018, p. 111).

Manne asks why we expect caring work ought to be continually given by women. She posits that when it comes to caring actions: the "goods are truly valuable" (2018, p. 110) – which is true. Take for instance the need for love, acceptance, respect, security, kindness, or attention, these are things that all humans desire on a regular basis. She writes that this type of work is needed and does "need to be done," however, we do not promote a social atmosphere nor subscribe to a political regime that supports the notion that care work is as valuable as intellectual or economic endeavours (2018, p. 111). As caring activities become somewhat sequestered to the domain of private life, or hidden away out of plain sight, we can imagine how social life was influenced by this.

Hochschild conceives of emotional labour, one aspect of caring work, that requires an individual to do private emotional management that draws on their own sense of identity (Theodosius, 2008, p. 22), whereas care acts that are organised and professionalised often take place in public spaces like hospitals, towards perfect strangers (Theodosius, 2008, p. 33). The concept of a 'nurse' is also imbued with cultural and social expectations, nurses are thought to be caring, patient, kind, and respectful. Hochschild writes that "nurses are often portrayed as the keepers and carers of emotional needs" (Theodosius, 2008, p. 31). However, a lot of caring work is silently produced and goes unnoticed. For this reason, it can seem invisible until it stops happening (e.g., the major shift in medical demands during Covid-19 and the effects on hospital capacity). When care stops happening, people start to notice and demand what is owed to them.

Again, caring roles are commonly left to those who are marginalised in our society, or as Tronto writes "caring work is reserved for the least socially appreciated" (2010, p. 166). This fact is reflected in the wages and salaries of those performing caring work, that is, janitors, housekeepers, nannies, and so forth. Those who are privileged can then afford (both figuratively and literally) to contract this caring work out to others, and therefore, neglect their own caring obligations (Tronto, 1998). Barnes and colleagues (2015) write that when powerful people do not acknowledge their own need for care, they simply fail to think that care has anything to do with them, a fact that is inherently untrue of human society (p. 6). The act of caring for persons then requires us to acknowledge the power relations involved in these relationships. Such power dynamics concern everyone but are most significant for anyone who has been imagined or deemed to occupy a lower status, such as a woman compared to a man, a child compared to a parent, an immigrant compared to a citizen, or a nurse compared to a physician.

Within these imbalanced relationships, oppressed or controlled individuals are thought to owe something to the other in the form of labour. Manne writes that a woman is "always somebody's someone, and seldom her own person. But this is not because she's not held to be a person at all, but rather because her personhood is held to be owed to others, in the form of service, i.e., labour, love, and loyalty" (2018). Similarly, in medicine, the caregiver's role is viewed not as a reciprocal relationship, but instead as a unidirectional giving of expert services and quality care in exchange for a modest wage. Arguably, in today's post-Covid healthcare climate, caring services can be provided without a disposition of care, since institutions may only gauge the quality of care on whether the caring actions have taken place, in which case, the work is considered to have been done. Additionally, there is no sense of obligation from the patient to imagine how they might be caring towards their provider, and often, a sense of caring between providers is lost in the milieu of competition, technical tasks, and shared exhaustion.

Tronto argues that "all human beings require care, all the time" (2010, p. 163). In this case, no one is ever immune from the essential human need for care. This includes hospital caregivers, who have been forgotten in the push away from paternalism and towards patient-centered care. So how have we gotten so far away from the basic tenets of care? In my view, through the act of being uncared for throughout our own personal histories (e.g., abusive parenting, bullying, penalisation by institutions, racism), from becoming accustomed to neglecting our caring obligations in the world around us (e.g., destruction of the environment, sexism, human rights violations), and by attempting to always hide away our essential need for care from ourselves and others (e.g., self-debasing attitudes, lack of self-esteem, isolation), we do not always approach situations in the world with a disposition of care. In the context of critical care medicine, and the themes generated from my autoethnographic data, one of my essential claims has been that caregivers also require care. The care that they need may not come from a reciprocal relationship, such as between two partners in life, instead, since patients are not in a position to care for their caregivers, the care they require needs to come from institutional support.

Going back to Tronto's point that care is more commonly practised than it is politically analysed, the word care is fundamental to medical practice (medicine is riddled with care-related terms, including care-takers, caregivers, care-plans, care ethics, standard of care, patient care, cancer care, mouth care, etc.) yet the *practice* and *disposition* of care are not always present within care-giving institutions. The implications of this statement are wide-reaching, given the complexity of caring relationships and the large requirement for care by patient populations. We can all imagine times when our need for care was not addressed by a caring institution or care-giving staff. Similarly, caregiving staff do not always feel supported or cared for by their institutions, colleagues, and support staff. Further to this point, we must imagine the complex and intersectional ways that people are affected by a lack of caring forces (i.e., those discussed by care ethicists) which include sexism, racism, classism, ageism, power dynamics, social hierarchies, and so forth. Such influences affect everyone from the highly oppressed patient all the way to successful surgeons.

A surgeon may simply feel entitled enough not to care. I have encountered surgeons who consider their status to be an excuse for their mistreatment and abuse of the staff working alongside them. I have watched these surgeons throw instruments across the room, throw temper tantrums, yell at nurses, or swear uncontrollably. These examples are indeed very dramatic, and so it is also important to remember that seemingly less egregious actions can be just as (or more) damaging to others. An example I have already used is when I was speaking with a surgeon over the telephone, and despite my best efforts to quickly address his needs, he interrupted me multiple times and insinuated that I lacked enough intelligence to solve his problem, only to hang up on me mid-conversation. He did not throw a knife past my head, an action that would provoke fear in me and risk my safety, but he did verbally abuse me which made me question my ability to be an effective part of the team. This was only one of hundreds of experiences over a span of time. Such instances make a person feel uncared for and I felt outright degraded. In contrast, other surgeons seem perfectly able to maintain a high level of professionalism and respect for others under the same demanding pressures and stress, meaning such behaviours are not required by the role.

Conflicts can and do arise when we enact care, and how care is received is often relative. Take for instance a nurse who yells at a patient to "stop it!" as she scolds them for trying to pull at their intravenous (IV) lines, lines that are necessary for their care. She seems to have a harsh disposition and is using unkind words, giving the impression of a callous nature, which is harmful to a vulnerable patient who may be in a very bad state of mind. However, she is also trying to stop the patient from harming themselves. Once the IV line is pulled out blood will spurt everywhere, another line will have to be placed, putting the patient at a greater risk of infection and they will have to endure another procedure. The nurse is also surely accustomed to patients pulling out their lines haphazardly in states of delirium or confusion, a fact that has given her less patience when dealing with such events. The best of all worlds would include a patient who is responsive and reasonable and a nurse who is patient and kind – but that is not always the reality of caregiving.

Consider another example, where a caretaker may show a lack of awareness towards a given situation. A physician needs to deliver bad news to a patient's family member, as is their role and responsibility, but they fail to acknowledge the fragile state of that family member and the nurse caring for them. As the doctor continues to dole out facts and describe possible avenues of choice, the family member demonstrates a vacant stare and is beginning to tear up, and the nurse is obviously looking stressed. Rather than take notice of the emotional state that these individuals are expressing, or make it known that they have observed their suffering, the physician continues to talk in order to fulfil their duty to fully inform decision-makers. For Tronto's purposes, this instance can be understood as a failed acknowledgement of a need.

In other cases, caretakers may show a lack of competence (or a failure to meet the need for care). Consider a patient attendant who says they will deliver a warm blanket to a cold patient, who never returns, although they are addressing other patients' needs; or lastly, consider a person who has good intentions but who totally misses the mark and ends up harming someone in their quest to care for them (e.g. a nurse who exclaims that her patient should be considered for end-of-life care because their health status seems unbearable, a belief that is purely based upon the nurse's own understanding and values, yet the condition is considered to be tolerable to the patient themselves). Structural pressures, like those discussed above (i.e., power relations, political regimes, institutional governance, and pedagogical practices) all contribute to decisions that may suppress caring action, as do individual values and perceptions about how to act appropriately. Consider the following story:

> "I don't know what else to do, I was just there," a patient pleads over a hospital telephone. "I think you should go to the emergency department ma'am, there's nothing I can do for you," said the nurse, "I already told you what your options are, I'm not sure what else to tell you." She says firmly.

From what I could tell overhearing this conversation, this patient appeared to have been discharged from the nursing unit the previous day and was now in pain having not filled her prescription medications before arriving home. The patient continued to beg for help and finally resorted to yelling her discontentment over the phone to the nurse, she felt it utterly unacceptable that the nurse would not help her, causing her to hang up the receiver mid-conversation.

> Outraged, the nurse exclaimed to her colleagues, "I did everything I could, she has to go to the emergency room, it's not my fault she was discharged early and is now bleeding at home, that was someone else's mistake!" Her fellow nurses rushed to her side, saying how it was indeed not her fault, and they were very sorry she had to experience such a berating from this patient. "She just started screaming at me," the nurse repeated over and over. "She told me she has cancer; everyone has cancer on this unit!" The nurse rationalised. Her colleagues continued to reassure her but soon left, one after another. They filtered out of the office to answer call bells, to address patient concerns, and to chart on their patients. There was some silence in the unit for a short while as the nurse sat alone. She was still mulling over her phone conversation. Eventually, she could no longer waste anymore time contemplating it, so she went about her usual tasks, now focusing her attention on the patients still admitted under her care.

The above example is a simple portrayal of how the political boundaries that separate medical care, such as the invisible lines between being an inpatient versus an outpatient, affect access to care. The location of the patient in their journey, or the exact designation they are given at any time, can affect their care. For instance, the above patient had crossed the boundary between inpatient care and outpatient care, making the inpatient nurse no longer responsible for them. The short period between the nurse's duty to care for the patient and their ability to decline to help them later marks a stark transition between their respective roles, which can feel somewhat arbitrary and harsh to the patient who has just been discharged. What was important was the political boundary that was drawn, affecting the patient's degree of access to the caring services they previously had easy access to. As an outpatient, this patient was no longer viewed as a responsibility by the nurse, who was now more focused on how this patient was taking away from their own tasks, instead of acknowledging the patient's distress and need for care.

To better see how caring activity can easily be concealed or ignored, consider a recent example. During the initial phases of Covid-19, a tremendous shift took place in the public's awareness about how nursing care (specifically intensive care) takes place in hospitals. There was a sudden acknowledgement of the hard work that is required to care for patients who are very sick, and/or intubated and sedated, and the emotional burden that is placed upon ICU nurses who have to deliver care to patients who are suffering. The truly difficult nature of this work was more readily grasped by everyone as nurses fully dressed in garb, masks, and gowns were shown behind glass doors caring for Covid patients. Communities showed their support and expressed deep appreciation for these caregivers (e.g., honking horns or banging pots to cheer on healthcare workers). The question is, why then?

Why was this particularly necessary type of caring, a type of caring that has existed for a very long time, relegated to the background until a pandemic brought it to the forefront? The notion of care, for me, then also requires a sense of *awareness*. By awareness I do not mean the acknowledgement that good care is being delivered, but instead, an awareness of the truth of what is happening around us and the ways in which people treat caring practices. Banging pots and pans in the evening for healthcare providers was a cultural movement, a public response to show appreciation for the very necessary care work that was being provided by dedicated caregivers. This sound rings hollow if the sentiment behind it only lasts for a short while when people might be afraid that they will not be triaged and assigned a critical care bed. This instance does not fit the four criteria of care, as outlined by Tronto, since there is no responsibility (taking care of), caregiving, or care receiving happening here, instead, there is only a short acknowledgement of a "need for care" or what Tronto calls "caring about," and thus, this does not constitute truly caring action.

Habituation and *detachment* estrange us from the knowledge of what it is like to practise caring acts, helping us to forget how to care well or fail to acknowledge or recognize when care is needed by others. I argue that the root of this phenomenon (i.e., ignoring, and neglecting care) is what helps to generate a lack of compassion for others, be it fellow co-workers (in competitive or harsh environments like the ICU) or otherwise. A lack of awareness about what individuals need to thrive in the face of trauma and grief becomes rampant in a world where it is not clear that anyone's values matter, and medical teachings are devoid of mentorship that promotes self-care. Thus, we need to spend time reviewing what an economy of care could look like, as well as how to revitalise our perception of caring activity outside of our own familial circles. Tronto rightly says, "there is no universal principle that we can invoke that will automatically guarantee that, as people and society engage in care, that care will be free of parochialism, paternalism, and privilege;" her argument is that because of this, care must be a conversation within political circles, not simply a private or personal matter (1993, p. 153).

Tronto's assessments of care help to describe the ways in which care has been largely neglected in society, having been assigned to those who have been oppressed or subordinated, and how care work often falls to those who have traditionally occupied caring roles (i.e., women). Thus, caring actions are expected to appear to have been "freely chosen" by the caregiver, despite being unevenly distributed to women in the private sphere of the home as well as in the public domains of life (e.g., nursing has predominantly been a feminine role) (2018, p. 47). Up until the 19th century, women were not even allowed to become professionally licensed physicians, and the medicine that they did practice may have been as midwives, or even labelled as witchcraft (Jefferson, Bloor, & Maynard, 2015, p. 6). Women have long been considered to be nurturing and caring and thus better suited to a nursing-esque role, although, this belief does connect to the social belief that they would not be capable or rational enough to do *real* medical work. It also undermines the value of caregiving work compared to caretaking work.

The work by Mayeroff, Gilligan, Noddings, Tronto, Dowling, Manne, and the Care Collective all look to better understand care as a concept, as a disposition, as an activity, and as a mechanism for social change (both locally and globally). Such delineations of care are important to note here, but unlike Tronto, Dowling, and the Care Collective, the focus of my argument is not targeted towards global change. For now, I am interested in the possibilities available to a single healthcare system, when imagining a structure that is more caring, and hypothesising how individual hospital units, and their staff, might better instil care for all. In this way, my work is most in line with Mayeroff, Gilligan and Noddings in that I pay particular attention to the individual, as well as to smaller caring relationships that exist between providers and patients, providers with other providers, and a provider with themselves.

In this project, I have further incorporated my own perspective on how providers can seek to care more authentically by becoming aware of the nuances special to dynamic clinical environments (related to social and cultural factors) and by paying attention to their own thoughts and beliefs that affect those around them. Care is not only a practice that is worth doing, people who require care are also worthy of this consideration. This discussion has hopefully instilled in the reader the ways in which passé cultural habits and institutional detachment form the subconscious culture of occupational spaces. However, our thoughts, feelings, words, and actions *now* matter, and can help to collectively reshape the ICU culture into one that is more caring, more sensitive to the diversity of individuals, more trauma-informed, and lastly, more engaged with the sensitive nature of individual lives. This requires having moral discussions, allowing emotional release, and developing supportive frameworks for caregivers.

6.5 Caring Requires Trust

In the ICU environment where I work, staff have openly made it clear that their own need for care has been neglected by management and the organisation as a whole. Nurses, in particular, argue that they work endlessly to care for others, to the point of exhaustion, only to hear that their own needs are not important, and their requests for support are deemed impossible. For this reason, it is not difficult to imagine why caregivers are either leaving their jobs or are finding it hard to give their full selves on the job. I cannot agree more with Tronto's assessment of how our need for care (as individuals) as well as our willingness to value caring work is continually undervalued and marginalised. Even resilience narratives, which are promoted as healthy, quietly still promote the "superhuman doctor who can cope with and handle everything independently" (Wong, et al., 2017, p. 337). Recall my nursing colleague, who recounted being scrubbed in for a liver transplant and not drinking, eating, or going to the washroom for hours: this type of behaviour is born out of medical culture and practice, it is taught to staff via the hidden curriculum, and it is mentored to them by senior staff.

The social world that medical providers exist in is not inconsequential, and the effects of our unconscious uncaring behaviours perpetuate a system that is rife with stress and mistrust. Most importantly, I want us to see how the various cultural and social phenomena discussed throughout this project deeply affect the way we treat ourselves and others. The way we treat ourselves and others *is* care work, and without a strong cultural belief system that upholds the tenets of an ethic of care, we will continue to debase our own self-care and that of others within occupational settings. This then contributes to considerable distress and further prevents healthy social relationships from forming. This is because in the throws of an uncaring environment caregivers do not personally thrive, authentically connect, or have the emotional bandwidth to fully support others; instead, they are left expending all of their energy individually surviving, deploying emotional labour, feeling alienated, all the while figuring out who they can trust, and what avenues of relief they can find.

These types of political and social circumstances degrade trust. Fostering trust in healthcare is highly important between clinicians and patients, however, it is also fundamental to running a safe and respectful medical ward. The entire interdisciplinary team must trust each other to act in the best interests of the patient as well as the team, meaning they put a lot of faith in each other's abilities. However, when a team must operate under the pressures of social hierarchy, or within a culture that is not well equipped to deal with conflict, grief, or ethical dilemmas, this team is more likely to experience the silencing of emotion, the deflection of trauma, and the harms that come along with this behaviour. If we additionally combine this cultural milieu with a disengaged institution or management structure, one that metaphorically will bang its pots and honk its horn at 7 pm but then fail to wear a mask in public, these factors *will* break trust and will make staff more hesitant to speak up, since they know they will not be heard.

Trust is also an important part of how we treat each other, and it can affect the expectations we have of others. I grew up in a household where doctors were not considered to be gods, they were simply people, people who did not necessarily *know* everything. Because my mother believed that doctors were not necessarily all knowing, she did not always trust them. My parents' mistrust would often lead them to be critical towards medical providers and as a result, they were more apt to not listen to them, and they were quick to accuse them of being ignorant or uncaring. In contrast to my experience, some patients have literal faith in their providers. In a documentary series called *The Surgeon's Cut,* episode four "Heart & Soul" follows Dr. Devi Shetty, a cardiac surgeon based in Bangalore, India, who is revered by his patients. The footage of Dr. Shetty shows his patients kissing his hands and praising his divine work; he himself even comments that he feels his hands are an extension of God's work (Cohen & Van der Pool, 2020). His patients do express fear and anxiety about the risks involved with open heart surgery, to which Dr. Shetty tells them "by the blessings of god, all will be well" (Cohen & Van der Pool, 2020). His patients appear to be reassured by this message, as well as by his reputation as a competent, experienced physician.

These are two radical ends of a spectrum, to be mistrustful or sceptical of the work of doctors, or to have full confidence in their skill and intention. Most of us sit somewhere in between these two extremes, and ideally, the average patient will have some normal reservations about the process of their treatment, but overall, they will trust that their caretakers or healthcare providers have their best interest at heart. However, to have faith that caregivers are trying to help requires trust to be built, and if this trust has been broken, it is reasonable for patients to withdraw, be suspicious, or feel defensive. In my family's situation, they had no concrete reason to mistrust doctors as a whole; however, some patients do have good evidence for this belief. Take for instance a patient who has had a bad surgical experience in the past, because of this they may be less trusting and more fearful or anxious towards a new surgical team. Due to their experience, they remember what the bad experience felt like, and they will have formed particular thoughts about how to navigate such a situation. A sense of mistrust can also be warranted and experienced more broadly by entire communities or groups of people. Consider the historical harms of medical research on Indigenous children in residential schools, the Tuskegee syphilis experiments conducted on black men, or the atrocities committed by Nazi doctors on Jewish prisoners during World War II, to name only a few examples.

So, what do trust and faith have to do with caring about healthcare providers? Considering my own experience, because I once held a deeply ingrained belief that caregivers working in healthcare institutions could not be inherently trusted, I found it harder to trust that they were going to care about me. My thoughts and attitudes about care, acts of care, and the competency to care well, were very reliant upon the knowledge that someone was going to be trust-*worthy* and that they also *believed* in caring for people. In my mind, if they did not care about the work they were doing, or their patients, I was justified in not cooperating, and I had to find ways to protect myself. In these situations, I also felt justified in withdrawing my own caring behaviour. In medicine, if we are critical and judge others as not worthy of trust or professional consideration, we more easily enact 'ways of being' that are opposite to those of care, further perpetuating a circle of uncaring behaviour.

6.6 Learning to Care

I have not always *cared* about healthcare providers as much as I do today. My mother was always afraid of dying, particularly of dying young and leaving her children alone and uncared for, a fate she eventually experienced. She was diagnosed in 2010 with stage III breast cancer (endocrine sensitive and HER-2/neu positive locally advanced left breast carcinoma) and died in 2015 at the age of fifty-six, leaving her twin daughters and husband behind to grieve her loss. Her initial fear began when she watched her own mother die suddenly from an aneurysm, a brain bleed at the base of the skull that was untreatable at the time but would have been treatable today. Her mother died when she was only eight years old. She recalls being forced to see her mother's body in the casket at the funeral and running away screaming. This event made her very afraid of death and dying and shaped much of her approach to her own body, medicine in general, and teaching her children how to approach health and illness. As children, my sister and I did not know any better, so we believed a lot of what she said and were sometimes afraid of hospitals ourselves. Her initial fear of death became a larger fear of medicine's inability to save people, thoughts that were then projected unfairly onto healthcare providers.

My mother was never *careless*, she would always take my sister and me to the doctor. She was vigilant in terms of watching us to ensure we did not hurt ourselves or take unnecessary risks, and never left wounds untreated or fevers unmedicated. She had a flair for healing herself in that she took great interest in the body, its ability to heal, and remedies for illness. She listened often to physicians on the radio and read voraciously about health and healing. Her main contention with the medical field was not that it was totally incompetent, instead, she felt they were unable to address the early stages of illness, it was too "last-ditch" for her. She used to say, "If you need your broken leg fixed, or your heart operated on – the hospital is what you want. But for anything else, they probably can't help you." This is of course a gross exaggeration, but the root of her concern is not entirely untrue. I remember visiting my family physician over recurring pain I had in my gut during my twenties, and the doctor explained to me that "until I develop an *actual* condition such as Crohn's disease, they could not really do anything for me." I thought to myself, "you want me to wait until I am much sicker before I begin to address the problem I am having?” Experiences like this helped to instil in me similar fears around the extent of modern medicines reach.

Because of how I was raised I had a lot of negative ideas about healthcare. I viewed it as a system only able to support crises of health (e.g., heart attacks) but never lifting a finger to help avoid them. In turn, I imagined those working in such a system to be callous, ignorant, and apathetic to patients' plights of health and emotion. I wondered if they truly cared about the patients they were responsible for, or if patient suffering affected them. There was enough evidence in my life to support the poor quality of care often delivered in hospitals. I had waited long hours in emergency departments, been treated as only a disease category, or passed off without a diagnosis. I was also privy to a host of stories from family and friends that were filled with complaints or grievances related to their care, or lack thereof. What I did not understand at this time was that the reality of delivering medical care was much different than this, I just could not see it as an outsider. I had no tangible context for what medical life was like beyond rumours, news articles, and my own patient experiences, making many of my “beliefs” mere assumptions. Most importantly, I had no real knowledge about how healthcare providers felt in their environment given the demands that are placed upon them. They were strangers to me, only silhouettes of people in scrubs holding scalpels. Little did I know, the truth was much more complicated.

In reality, healthcare systems cannot reach all aspects of our lives. Medical professionals cannot ensure citizens will avoid every ill-fate of the body or mind, nor can they always tell us what to eat, how to think, or how to act. This is somewhat the goal of public and global health efforts which have undertaken educating people about the harms of our environment in terms of drinking alcohol, smoking cigarettes, inhaling asbestos, or ingesting unhealthy foods, as well as how to avoid transmissible diseases, viruses, or pathogens. Firefighters help educate people about housefires, police advise against drinking and driving, and mothers, fathers, family members and teachers all help to advise children how to avoid harm like sticking forks in outlets or drinking antifreeze. We have further chosen as a society to organise and professionalise the more arduous and complex methods of care delivery, such as surgery, dentistry, or pharmacy. Health and healing are indeed a community activity and a relational practice. The truth is, that even when care has been delivered competently and with the patient's best interest in mind, those on the receiving end of care may still be dissatisfied (we can think back to Tronto’s idea of care receiving).

Once I became an insider, I began to see things differently. I could see the ways in which the system truly functioned and how it was designed, the barriers and pathways became clearer, and the motives and actions of caregivers were more evident. I would watch and listen carefully to people in these settings, as I was often tasked with helping entire groups of people. I was not only responsible for assisting one doctor or one patient, I had to ensure the flow and cooperation of all nineteen OR’s, making sure to keep the peace, prioritise tasks appropriately, and be on top of things. These experiences taught me so much. Over time, I had to consciously set aside my own misguided and outdated beliefs since I had witnessed the realities on the ground. It was only after being a part of the team that I could access different and unique perspectives. With greater insight into the struggles of caregivers, knowledge of their environments and personalities, it became apparent what their limits and needs were, meaning I began to learn how to care for them.

We can only choose to act differently when we see how our choices affect others and ourselves. My lack of care was never purposeful, in fact, I was completely unaware of what I was doing when I would unfairly make judgements. I was merely acting out of a sense of purpose and values (i.e., seeking justice for patients) based upon the beliefs that I had. Judgments like "nurses don't care," "doctors don't listen," or "hospitals are dangerous." These statements are sometimes true, but they are not *always* true. They are also examples of black-and-white thinking, whereby situations or ideas can only be one way or another, that is, either all doctors listen, or none of them do. A person might also generalise their experiences, making a single instance more reflective of a greater truth, seeing them as proof, or what we understand to be confirmation bias. Further to black-and-white thinking, an individual may see their point of view as indisputable fact, causing them to act out of a sense of entitlement; we can think back to Nel Noddings who made the point that "wherever there is a principle, there is implied its exception and, too often, principles function to separate us from each other" (1984, p. 5).

The act of "not caring" is something we are all capable of. To be uncaring, one must fail to consider – or act in accordance with – the thoughts, feelings, and needs of others. There are many general definitions for the word "uncaring," all of which refer to its meaning as a lack of concern for others, not worrying about the troubles of others, not helping those in need, or a disregard for those in a bad situation. Here we can also see that not caring is to fail to adequately meet all of Tronto's four phases of caring. A key feature of each one of the four phases is that they all require intention, motivation, or action, so to 'not care' becomes a failure of the uncaring individual to act appropriately, and the impact is an ethical one, which is the residual effects had on the recipient who does not acquire the care they need. We may sometimes actively choose to be uncaring, or we may do it unconsciously. Either way, individuals who do not realise when they are being uncaring, or how their uncaring attitudes affect others, are still responsible for the harms that come from this behaviour.

In hospitals, I am very concerned with the ways in which caregivers have felt excluded, judged, or embarrassed, have experienced microaggressions, have been abused through language, and have even experienced violence (e.g., having a scalpel thrown across the room at them) by people who have never learned how to care for others despite being in a professional caregiving role. Similar to the Institute of Medicine's (IOM) approach in their book *To Err Is Human: Building a Safer Health System* (2000) (which reveals the often-startling statistics of medical error), I do not place blame upon individual caregivers for their actions, instead, I am interested in addressing the systematic behaviours and the culture of medical spaces that perpetuate uncaring ways of being and uncaring dispositions. We have explored in this project how uncaring behaviour can be a symptom of existing in a harsh environment where protective mechanisms are required to survive, which later guide our more automatic behaviours. Therefore, to address these behaviours and the harm they cause, I do not feel that blame is a solution, instead, similar to what the IOM argues, we need to promote a system that makes it harder to be uncaring.

This cycle – one that is perpetuated by senior staff harming more junior staff, and those junior staff later harming new residents or nurses – thrives off what was taught to us, or what we felt protected us from harm in the past and present. To break the cycle, we must stop and examine ourselves, examine our behaviour and that of others, and decide what we think is justified or beneficial and what is harmful and unnecessary. This is when ethical choices can be made to determine the type of behaviours that will or will not be condoned in medical spaces. We take for granted that people *know* how to care well, or we assume that people know how to be caring by virtue of being professionals or prestigious members of a group or society; however, teaching professional behaviour does not equate to teaching a person how to assess the needs of others authentically and care for them in an appropriate way. This is especially true given the highly technical focus of the Western biomedical model of medical care. Milton Mayeroff says:

> "We sometimes speak as if caring did not require knowledge, as if caring for someone, for example, were simply a matter of good intentions or warm regard. But in order to care I must understand the other's needs and I must be able to respond properly to them, and clearly, good intentions do not guarantee this. To care for someone, I must know many things. I must know, for example, who the other is, what his powers and limitations are, what his needs are, and what is conducive to his growth [*arguably facets of a patient's personhood that are not explored in the emergency room*]; I must know how to respond to his needs, and what my own powers and limitations are. Such knowledge is both general and specific" (Mayeroff, 1971, p. 9).

Understanding how to truly care for caregivers has been an integral part of my own journey through critical care, as well as being fundamental to my research process. Today, I care deeply for *all* healthcare providers and have dedicated this research to helping deliver my promise of care. I am also cognisant of the fact that my previous inability to see their *need* for care (not a need rooted in a lack of capacity or autonomy, but simply a need for certain humane circumstances to effectively deliver critical care without depleting the self) helped to shift my perspective, and this required bringing myself into my own research. My own experiences, emotions, and processes had to be under the microscope as well. To know what care truly requires I had to become more caring myself, I had to take these steps without resorting to shortcuts. I had to see what caregivers see, and feel what they feel, and only after I gained some sense of their inner worlds was I able to stop and realise: first, that we have to be better to each other, second, that there needs to be more support for caregivers after critical incidents, and third, in order to properly support caregivers we need to acknowledge and accept their emotions without judgement.

Importantly, I have learned throughout my research that caring is a process and that there is an important distinction between caring *about* and caring *for*. Caring does not happen overnight, and knowing how to care well can take time – and it often starts with the self. After all, a person cannot give something that they do not already have themselves, in this instance, knowledge of how to care. Caring can require time to personally reflect and time to gain awareness of oneself and others. Care is also nuanced in that people may require different approaches in order to feel properly cared for, but care is somewhat universal in its overall intention, which is: to accept what is, and to comfort and support those involved. As this chapter has explored, "the concept of 'caring' is developed by disclosing its relationships to other significant concepts like 'trust,' 'honesty,' and 'humility,' and it also grows through coming to terms with seeming exceptions" (Mayeroff, 1971, p. 8).

Chapter Seven

Tying Things Together

At this point, I have walked us through many concepts, ideas, theories, and arguments that may feel somewhat disconnected but are still in fact connected. Their connection lies in the *relational* effects these forces have on the human mind, body, and psychosocial life. To recap, we have discussed: a person's susceptibility to, and their degree of *occupational stress*, and whether or not this stress has led to physical, emotional, or social disorders (e.g., anxiety, insomnia, depression, or trauma); a person's *awareness* of themselves (the degree to which they acknowledge or are aware of their own feelings, their circumstances, and how they are being treated) and their awareness of others; a person's *identity*, or how they perceive themselves both in their personal life and in their professional work; a person's emotional management skills, or the *emotional labour* that they are expected to engage in within institutional constraints, rules, and regulations (i.e., the ways in which they are socially expected to manage their emotions appropriately); a person's sense of connection to, or *alienation* from their work and their creative outputs, for example, are they able to individually express themselves and engage in compassion while caring for patients, or is their labour only valued as monetised action; and lastly, a person's understanding of, and connection with *care work* in healthcare, in other words, what type of caring are they involved in (with patients, families, or staff) and how appreciated or supported that care work is, e.g., whether it is socially unappreciated (a nurse emptying a urinal) or socially praised (a doctor writing a prescription).

These concepts are interrelated because they all share one thing in common: these are all forces that socially shape and drive individuals to contort or adapt their mind, body, psyche, and behaviour to fit in, remain safe, feel accepted, and receive care within their institutional context. Some of these categories/themes represent larger social pressures or are socially constructed, such as the concepts of alienation, emotional work, and care work, which function broadly in society (not only in the workplace); whereas others are more philosophical and abstract, such as personal identity, integrity, and awareness. The ICU environment would not exist without the people. The people who work in ICU have expertise and jobs to do, but they also have choices to make. They can choose to be open-minded, to be patient and listen, and to question the status quo, alternatively, staff can choose to remain unaware and perpetuate old behaviours, join in on bullying behaviours, or remain silent rather than speaking up.

Occupational stress is not a stand-alone phenomenon, it is deeply integrated and affected by our awareness of what's happening around us and inside of us, our sense of self and our values, our connection to our work, our beliefs about our work, our ability to be genuine with others in the workplace, our ability to discharge emotions freely, and our ability to feel cared for and safe. The cultural adaptations of any medical profession, medical group, or even medical wards, are shaped by the people that operate in these spaces, which will affect the acceptance or rejection of individuals based upon the group's beliefs around cultural acceptance and what is required for a person to comply with these cultural rules. These social pressures can be subtle or forceful and can mould people to act in ways that are inauthentic to fit in and be socially appreciated, protected, and supported. The degree to which people feel accepted lends to their ability to further express themselves, as well as to fully actualise themselves in their careers and feel fulfilled. In critical care, there is a lot of occupational stress but there are also many opportunities for growth and change.

Let's bring the core concepts back to our original research questions, which included: (1) Do repressed, ignored, or unprocessed emotions contribute to occupational stress in critical care? (2) Are the ways in which contemporary medical institutions approach caregiver emotion (i.e., the culture of ignoring, and shame/repression) contributing to/perpetuating occupational stress? (3) Can a critical examination of personal experience (i.e., what is felt by a single caregiver/healthcare worker daily) teach us about occupational stress? I feel that I can confidently answer yes to all three questions. Related to the first question, I have provided extensive evidence for the effects of stressors that exist in the critical care workplace, as well, I have noted the *absence* of consistent emotional support and the *presence* of emotionally repressive pressures. Related to the second question, I have drawn our attention to the awkward culture of guilt and shame that revolves around emotional experiences in medical spaces, which still exists today, despite major shifts in medical education and mentorship models.

To address the third question, I would argue that yes – the examination of a single caregiver's experience can help us *begin* to understand occupational stress. This is because, within the phenomenological experience of a single caregiver, a researcher can draw out and examine a level of detail that would be exhaustive or impossible for larger groups. A single caregiver's experience is also reflective of and internalises the experiences of many others, even if it is only told from a single perspective and is limited in other ways. The work I have done over the past 14 years to better understand the topic of occupational stress is extensive and requires years of exposure, learning, critical thinking, organizing thoughts, and examining feelings, all of which culminated in the preparation of a rigorous research project – but this was not the purpose of the project. The real purpose of the project has always been to find an answer to my original question, which was to ask: how can we *feel better* in the ICU?

By examining how my values, beliefs, and behaviours influenced the larger project – being curious about the effects of occupational stress on myself and my colleagues – I was able to detail the story of my comprehensive lived experience in healthcare, in a real community setting. Steketee, Archibald and Harden (2020) argue that "autoethnography combines two central components of science—observation and critical thinking" and "what autoethnography lacks in conventional control and a priori systemization is made up for by ongoing, interdisciplinary, theoretical dialogue, and critical reflection" (p. 7). I feel that I have successfully examined the components of my experience that are relevant to occupational stress and that the insights gained in this project are valuable for the community that they are directed towards. The rest of this chapter is dedicated to further explicating the six core themes and their connection to ICU and occupational stress.

7.1 Occupational Stress as a Mechanism for Survival in a Hostile Environment

As discussed throughout this project, occupational stress comes in many forms: it can be triggered by various activities, events, and people, and it can manifest in many ways, for instance, as anxiety, fatigue, annoyance, cynicism, or mental illness. I hope to have instilled in the reader that occupational stress is dependent upon *many* variables, and it affects individuals, groups, cultural groups, and institutions alike. The effects of occupational stress can be categorised and studied, and even labelled (e.g., burnout syndrome, moral distress, post-traumatic stress), and it is obviously worsened by workplace stressors, including, but not limited to too much work, not enough autonomy, poor management, a lack of resources, a violent culture, or traumatic situations. The fact is, individuals who are put under extreme occupational stress *will* resort to coping strategies to deal with this stress (e.g., avoidance, outbursts, apathy, attrition) and they can also resort to internalising this stress which may then manifest as illness (physical or mental). I want to impress upon the reader again that coping in the face of stress is a normal human reaction, however, illness derived from stress that continues for too long is harmful, unsustainable, and preventable.

Resilience is a term we discussed earlier on, and it is this quality that is said to protect individuals from burnout or occupational stress. However, given that resilience is widely variable, we cannot expect resilience to be our saving grace. Resilience is an excellent quality for any individual to have, however, the quality of being able to bounce back easily from stress has not been taught to everyone. Not all caregivers will have had the benefit of loving parents, a safe environment growing up, feelings of security and nonjudgment, or the same privileged opportunities as others. Given this, the historical features of how a person grows up and the ways in which they develop in their environments, including their adaptations to nursing or medical school, and even residency and senior training, will all dictate a person's level of resilience over time. Liminal phases, where learning happens, are critical for professionals especially during their identity formation. For this reason, occupational stress must be addressed at the level of the institution, the culture, *and* as it relates to the individual.

One of the main takeaways here should be that the features of occupational stress, or the responses that people have in the face of constant distress – being exhausted, disillusioned, depersonalised, and unproductive – are normal ways of coping and surviving in a hostile environment. Yet, these coping strategies are a sign that the environment is threatening to individuals and, therefore, is going to give rise to a lot of uncertainty, unpredictability, and social precarity. I have witnessed a lot of different types of care over the years, and whenever a case is coming to the ED for stabilisation, the OR for surgery, or the ICU for care, it can be very stressful. Yet, caregivers are highly focused and perform the emergent tasks at hand without hesitation. Fast-paced areas of care like these specifically hire, train, and seek out people who thrive on this type of work and the energy it brings, including the high levels of stress. However, there is a difference between the stress that comes from the painful sights and sounds of patients who are injured or sick, and the types of stress the system creates or that caregivers perpetuate. Therefore, critical areas of care are necessarily stressful in some ways, and unnecessarily stressful in other ways. Given the degree of stress that manifests in these environments, any reduction of stress is useful.

My argument for reducing occupational stress is highly focused on emotional processing, and how caregivers should have an opportunity to process the events of the case after the acute stress has died down and the patient has been successfully "cared" for. My overall concern is the lack of opportunities providers are given to decompress, release, and process emotions after the critical incident has diffused.

7.2 Awareness as a Mechanism for Personal and Social Change

Awareness is "knowledge or perception of a situation or fact" ("Awareness," 2024). Having awareness or knowledge of social constructs, harmful social behaviours, and the unjust mechanisms of institutions, can free individuals from their constraints. Once you can clearly see the ways in which a culture operates day-to-day, or the nuanced ways in which you yourself act/react daily, you are then able to pinpoint ways of being that are productive, and ways of being that are harmful (e.g., interrupting, yelling, blaming, or being violent). Awareness is what I required to overcome my own trauma and stress. I had to take time to examine my life to bring awareness to the things I had experienced and to acknowledge that I had undergone stressful events. I also needed to start seeing the coping strategies I was employing, and the physical and mental manifestations of my stress (which I was ignoring). You cannot heal systematic trauma by ignoring it, it needs to be acknowledged, and by definition, you cannot acknowledge something that you continue to ignore. I was able to heal from the trauma of the past by realising the truth of my experience, which required accepting my feelings of sadness, anger, and grief (which were natural and reasonable), and showing myself compassion in the moment.

Awareness of oneself, the environment, and others is like having a superpower because it can allow a person to engage directly with their circumstances in a very authentic way, which can be used to instil personal and social change. Especially in a setting that does not prioritise emotional authenticity, or instil the freedom and courage to speak up, individuals must take extra steps to notice what is happening around them, as well as to notice what is happening inside of them. No one is going to do this work for us, as it is highly personal work – to actively choose to pay attention to our feelings (e.g., our beliefs, thoughts, and resulting emotions) and how we behave (e.g., our words and actions). In medicine, I call on all of us to bring what has been hidden in our psyches, hearts, and bodies out into the open – the events, scenarios, toxic relationships and damaging words and behaviours that have been relegated to the background and that continue to make us silent. Only then can we begin to appreciate how our shared circumstances, our emotional diversity, and the hurdles we all face together can be better dealt with using compassion rather than repression. Successfully treating occupational stress then requires treating the *social situation* as well as the individual.

7.3 Identity as Social Caste, and Identity as Personal Power

The culture of medicine is not only perpetuated by misinformation, bad habits, and cultural rules, the very social nature of institutions is also based upon the stratification of personnel, or hierarchy. For some reason, the less appreciated people are, either because they are politically relegated to lower social 'castes' or because they sit at what we would consider to be the bottom of the social hierarchy, the easier it seems to be to abuse these individuals and get away with it. There is a dehumanising aspect to hierarchy, which sets some people above others. To avoid or escape being relegated to lower social positions, people struggle towards the top, to claim worthy titles, to be afforded the luxury of safety and protection, or to reap the benefits of status and high regard.

Medical institutions, hospitals, and healthcare administrations do stratify occupations within the hierarchy of status and power. This fact is important to acknowledge when it comes to devising solutions to occupational stress because some individuals will have less recourse for managing their stress and/or will have more trouble accessing the support they need to overcome challenging situations. If we were to examine more deeply how discriminatory practices such as classism, racism, sexism, and ageism all affect a person's occupational stress, we can also imagine the ways these pressures will affect different caregivers, such as who is believed, who is taken seriously, and who can hold who accountable.

In this way, professional identity plays a major role in a person's ability to navigate stress and avoid, manage, or overcome distressing situations. What recourse is there for the medical student to stand up to the abuse of a surgeon? Or the nurse to stand up to the administration? We need to develop a system of compassion, for all people, no matter their station. Our identities should not be divided into various levels or castes, instead, our identities should be a source of personal power, a way for us to navigate difficult medical situations with the expert knowledge of how to approach the emotional diversity of others and to speak up when something is wrong. Getting to this place will require dismantling outdated beliefs that higher education is equal to emotional intelligence. It will require a rethinking of identity and professional titles within an institution and an examination of how status affects the treatment of personnel.

I have only experienced a handful of emotional discussions or debriefings at work, which were very infrequent, and what often surprised me was that this task was always designated to the "most responsible healthcare professional" – most often a physician (usually, not a resident, but a staffed intensivist, surgeon, or anesthesiologist). The administration seemed to have collectively and unconsciously decided that the professionals who had the most *medical* knowledge would also be best suited to help their fellow caregivers decompress their emotions after a case. However, if we think about it for a second, this line of reasoning is quite problematic. The "most responsible" healthcare professional, while expertly suited to manage a coding patient or a traumatically injured patient, is not necessarily an expert at being sensitive and caring.

These caregivers also sat at the top of the hierarchy and held power over these individuals, creating a very clear conflict of interest in these situations. Further to these concerns, these experts were often at the head of very difficult fields of medical practice, such as surgery and critical care, meaning they had undergone training that had likely purposefully hardened them to their own emotions and difficult situations. During the debriefs I would watch as they comported themselves in a way that was visibly uncomfortable, giving advice that was shallow or dismissive, while rarely acknowledging the true feelings of those situated outside of themselves. One of the cornerstones of effective emotional work is being able to check your status and ego at the door so that you can fully engage human-to-human with your colleagues as an equal and as someone who is both willing to share and is open to learning from others. This is how we empower each other to speak up and to make change.

7.4 Emotional Labour is What is Exhausting

Given the fact that everyone is unique, we must also come to expect that individuals are *emotionally diverse*. In other words, people have diverse neurobiology, diverse hereditary factors, diverse childhood and adult experiences, and diverse predispositions to certain mental health disorders, as well as diverse ways of handling emotional experiences. For this reason, we cannot expect people in healthcare to react in similar ways to traumatic or stressful experiences. The hidden curriculum of mentoring, and the void of healthy emotional management education, all seem to instil in healthcare providers a sense that they must respond to stress in similar ways, and if they don't, they aren't coping properly. This is simply not true. This harmful belief makes caregivers feel that they must find ways to hide how they feel, lest they be deemed unprofessional, incompetent, or weak. This pervasive cultural expectation permeates almost all medical experiences, even if it is only in subtle ways. In my own experience, the emotional expectations of caregivers are unreasonable. The expectations are simultaneously that caregivers will have a robust repository of compassion and empathy to give away, yet they should ignore their own feelings and personal needs.

The reasons for hiding emotion, and the need caregivers feel to manage their hearts (as Hochschild would say), are connected to a belief that must be re-examined, for example, caregivers must protect their patients from their own hysteria or emotional outbursts. This belief is seemingly connected to the need to appear competent as the provider, as well as to maintain one's dignity in front of colleagues to garner their respect. Lönn, et al. (2023) give two examples of this type of reasoning by medical students who recount their experiences with emotional challenges in reflective essays (p. 1560). The students reported that failing to control their feelings in medical situations resulted "in unwanted internal and external emotional expressions" and "students referred to feelings of shame, decreased communicative ability, and a lack of focus" (2023, p. 1563).

> "The better I get at keeping my desires, feelings, and instincts under control, the better opportunities I will have to develop my empathy and other good attributes which will benefit me and my patients" (student no. 18) (Lönn, et al., 2023, p. 1563).

> "It was an expected death of an 83-year-old lady and yet I became deeply affected. Afterwards, I felt ashamed of my selfishness, getting so emotional in front of my supervisor but also in front of peers and the patient's family" (student no. 73) (Lönn, et al., 2023, p. 1563-1568).

Adhering to false beliefs that create internal pressure, but which are socially constructed and maintained, can cause distress. In addition to this, external pressures keep these practices alive and well, as mentors may tell their residents to "not cry," senior nurses may bully newcomers, and administrators may ignore requests for safer circumstances in the workplace. These responses reinforce uncaring behaviour and produce the perfect circumstances for emotional management strategies to feel necessary. The consequences of 'not acting appropriately' are what perpetuate this cultural behaviour and instil in workers that there are ways in which they *should* be acting – that is, the feeling rules. Certain behaviours are rewarded, which helps to ensure that people will continue doing those things, and others are punished, in the form of silencing, ignoring, criticizing, demeaning, dehumanising, or scolding them, which reminds workers which emotional reactions are prohibited by the culture.

The act of managing one's emotions from time to time is not problematic. What is detrimental to caregivers is the excessive use of emotional management strategies to cope and survive within an unhealthy culture despite the harm it is causing them. The reasons for this are two-fold, first, the act of producing an emotion that is not authentic (or is fake) requires energy and/or requires emotional labour which can be exhausting for caregivers, who now expend much of the little energy they have on pretending. Second, the act of consistently acting in a way that is not “real” or authentic contributes to a fake culture of behaviour that becomes counterintuitive and problematic to navigate (especially for outsiders). Becoming accustomed to repressed and uncaring environments also means that people are more likely to ignore and continue these repressive and uncaring behaviours, mentoring them to others and instilling them in newcomers. Mastering emotional management skills requires a person to alter their normal behaviour habitually and consistently and/or repress the true ways in which they are feeling. When we deny our emotions or expertly hide them under the surface of our conscious awareness, then they become much harder to address and treat. This behaviour creates opportunities for illness to develop and risks poor mental health becoming invisible or overlooked.

Consider the example of a nurse who is caring for a patient daily who is slowly dying from system-wide cancer. Every day the patient’s husband and her two little girls show up at the bedside to visit, which the nurse finds very hard to watch because it is a very sad situation. She avoids making eye contact with the family but often skips her breaks to ensure they have everything they need. This nurse then begins developing headaches, fatigue, insomnia, and gastric pain, but she reports feeling well to her colleagues and is uncertain as to why she is having these symptoms. Over time the nurse's symptoms worsen, as her patient gets sicker and sicker, but she fails to acknowledge the connection. To address bodily and mental distress like this, we need to (1) be aware of it, (2) acknowledge what our feelings are and what is causing them, and (3) engage with those feelings in a healthy way that respects a person’s individual way of processing things. These processes are necessary to avoid the compounding effects of emotional distress over time and require space, time, and resources to achieve. Emotional awareness and intelligence are skills that require practice, and like care, they are *ways of being* that require patience and support.

7.5 Alienation as a Side Effect of Rejection, Silencing, and Inauthenticity

I would like us to think back on the personal history that I disclosed at the beginning of this project, related to when I was scolded by my mother for eating, or not eating, and how I felt humiliated by her when I did not meet her expectations. This treatment not only taught me to hide my less desirable emotions from her, but it also estranged me from my own natural reactions to emotional scenarios. Rather than feeling safe to express myself freely, I was conditioned in a way to believe that my circumstances were *not* safe and that punishment would follow inappropriate or *undesirable* behaviours. This estrangement from my natural feelings and my inability to freely be authentic created a lot of resentment inside of me. I resented the rules that were put in place, which I felt were unfair and unnecessary, and I resented the person who held power over me, someone who truly believed that their feelings and desires were more important than my own. When we teach caregivers that the patient's emotions are of the utmost importance, but that their own emotions are undesirable and should be hidden, we promote a culture that represses these individuals and downplays the importance of their intuition and their care work. On top of this, if you put caregivers in situations that require a lot of emotional strength and stamina, with few outlets for relief and catharsis, it is a recipe for resentment and anger – feelings that can lead to isolation and alienation.

Caregivers who are resentful or angry could very likely be less willing to do a good job, not because they do not desire to do well by their patients or their institution, but because they are being put in a situation where they feel uncared for and depleted. This goes back to Marx's concept of alienation, a "distinct kind of psychological or social ill; namely, one involving a problematic separation between a self and other that properly belong together" (SEP, 2018). For caregivers, there are many problematic separations that I see, including (1) between the care work they do and the ways this caring activity is valued, (2) between their ability or inability to care *well* and how this affects their patients and their sense of accomplishment and self-actualization on the job, (3) between the caregiver and their own emotions (having a strong internal awareness of themselves and others) and lastly, (4) between patients and caregivers who are emotionally silenced which dulls their ability to authentically connect and engage in empathy.

In Chapter 5 we discussed how being separated from the fruits or material facts of one's labour (i.e., successful caring action), as well as from the creative and natural processes of conducting one's work (i.e., the art of medicine and healing), can be alienating. For caregivers, these separations are built either through physical means, including technology, paperwork, walls, and policies, as well as through social restrictions, such as those that are governed by politics, hierarchy, and professional scope. Caregivers want the patients they care for to feel better, to improve in health, and to be comforted; in other words, they want their efforts to have a positive impact and to be effective. These problematic separations weaken the relational connection that is necessary between a caregiver and any care receiver in a very literal way, preventing people from being able to create the necessary bond that is special to truly empathetic caring.

A sense of alienation is also bred through the political and social ways in which care work is undervalued and unappreciated. Care work is inherently valuable and should be viewed as such. It is work that is both necessary and required by most members of society at some point in their lives, if not at many points throughout their lives. The attitude that 'care work' is menial and that it should be delegated to the members of society who we least appreciate is the root of *bad care*, for Tronto. Beliefs like these contribute to our ignorance, as we continue to believe that caring activities have nothing to do with us, or that our uncaring habits are normal and justified. Again, when a person is not properly cared for, it is not surprising that they may act out in ways that are uncaring towards others. In other words, we cannot expect caregivers who feel deeply alienated from their professional roles and who feel abused and neglected by the system to be perfectly empathetic towards others.

7.6 Care Work as a Mechanism for Justice, Instead of Oppression

Finally, we come to care work as a way to seek justice rather than as an oppressive mechanism for silencing caregivers. Care work is not simply fluffing a pillow, asking if a patient feels okay, or handing them post-operative instructions for when they get home (although, these are caring actions) – as Tronto outlines, care work is complex, it affects many things we do in our lives and in the workplace, and it requires more than simply acknowledging a need, or sending monetary support. Care is a comprehensive and relational activity that requires: the *acknowledgement* of a need (i.e., that care is required), *taking care of* that need; taking on the responsibility to care for another and *providing caregiving* activities that are competently performed and are designed to care well for that individual; and lastly, responsiveness from the person being cared for to indicate that their needs have been adequately met, that is, that they have been *cared for* successfully. Not all caring activities meet all four criteria as devised by Tronto and Fischer, and this may go back to education and political priority. It also goes back to how well-valued care work is, and who is expected to do it.

Caregivers in public hospitals often lack adequate resources (e.g., access to machines, medications, safe staffing levels, or expert services when urgently needed) to do their jobs in a caring way. They also have very little time to complete tasks, are forced to do less with more, and are rarely given time to process stressful situations. They face limited support from colleagues and the administration who are also busy and overburdened, and little support from patients, who are not in the position to care for caregivers, as they themselves need care. Caregivers who face mistreatment from colleagues, patients, or the administration can feel as though their role is not valued and they are unappreciated and under-supported. In a truly caring institution, caregivers should feel safe to voice concerns (without the need for excessive moral courage), to speak up for their rights and those of their patients, as well as be able to hold higher authorities accountable for harmful actions towards them.

When caregivers are finally given the care that they deserve, which will allow them to act from a position of health and internal strength rather than from depletion and exhaustion, they will be able to focus their sole attention on delivering expert care to their patients. From the evidence in this project, caring for the caregiver is not necessarily that complicated, but the effects of uncaring behaviour are extensive and have major effects on healthcare systems. In order to prioritise care we must reinstate the value and priority of this work, move away from the oppressive nature of viewing care work as simply a passive obligation, and instead seek to see the true value and benefit of care work that extends beyond the scope of patient care alone.

Chapter Eight

Conclusion & Discussion: Explicating My Theory

In my experience, the cumulative effects of stress, distress, and emotional suppression – which are unrelenting in medical spaces – play a huge factor in how staff respond to their institution, their coworkers, and their patients. These pressures also deeply affect how individuals deal with their own mental, emotional, and psychosocial states, and whether they accept and process their feelings, or reject and ignore them. To experience only a few instances of emotional suppression or emotional labour is a normal part of being human, however, routinely suppressing one's emotions in highly stressful situations is not.

The damaging effect of emotional repression is that these actions predispose caregivers to further harm. The primary harm is in preventing caregivers from being authentic and from accepting their own emotional processes. Secondly, continued emotional repression, disconnection, and dissociation will eventually manifest either as physical or mental illness, occupational syndromes like burnout or compassion fatigue, or as moral distress or moral injury. By the time caregivers are alienated from their jobs, alienated from their feelings, and separated from the meaning of their work – this will also affect patient care and the patient's experience in the hospital. Thus, caring for the caregiver is another way of caring for everyone.

Medicine is a relational science/art, and its very purpose is centred around helping people to feel better, relieve suffering, recover, heal, peacefully die, or overall to find a therapeutic resolution for whatever ails them. If you separate the nurse from the patient using machines, charting, rounding, paperwork, and telephone calls, and continue to expose them to complex decisions, morally compromising events, and consider their emotional reactions to crises as unimportant, this sends a clear message, namely that "we don't care about you."

It has now been fifteen years since I walked into the operating room (OR) as a stranger, an onlooker, and a fearful layperson. It has been six years since I became a member of the critical care team. The results of my experience have left me with a brand-new perspective. In both units it took years to acclimatise to each setting, during which many of my walk's home were spent with tears rolling down my cheeks, coming to terms with what I had seen or how I had been treated. Bloody stab-wound victims, limbs hanging from bodies, amputations of body parts, fully burned bodies after a fire, suicidal patients whose faces were disfigured by self-inflicted gunshot wounds or hung themselves, even a young girl who had swallowed coloured pencils and cut off her ears during a state of psychosis; as well as being scolded, yelled at, demeaned, cursed at, made fun of, or ignored. Yet, as I acclimatised and became more and more aware of my emotions, I was able to relax a little more, advocate for myself, speak up when people were rude, and call attention to the need to discuss our emotions in medicine.

My initiation into medicine was necessary to reach a very important conclusion, one that is the heart and soul of this research project. I had to realise that it was not that healthcare providers were apathetic towards patients or that they did not care, it was that major constraints placed upon providers in their role made it very difficult to enact caring action successfully. Their hands were systematically tied, and their hearts were rarely the priority. Even in times of great emotion, such as witnessing the traumatic death of a patient, caregivers were expected to hold back their tears and move onto the next patient admission, most times with no acknowledgement of their own grief and trauma.

My experience has been that despite an increased awareness of the need for empathy and compassion towards patients, as well as extensive literature dedicated to protecting the mental health of medical personnel and towards decreasing levels of burnout, little attention has been paid to the effects of suppressing and ignoring emotion long-term by caregivers and caretakers due to the implicit notion (one that is deeply embedded within medical culture) that: *truly competent and respected professionals do not show their emotions to the patient or to colleagues lest they appear unprofessional and weak, and thus be deemed incompetent*.

8.1 How to Care Better

The overarching 'call to action' in this project is for us to begin to see *all* our caring needs as legitimate, to dismantle our gendered view of caring tasks, and to better understand the subtleties and labour involved in doing caring work. The lines which have metaphorically been drawn in the sand to separate our personal feelings from our professional lives may need to be gently erased. Giving "good care" may require an erosion of the myths that perpetuate ideas like "women are nurses" and "men are physicians" or "Latina women do the housekeeping." We also need to shift our perspectives away from ideas like "only nurses care for patients in emotional ways," or "being professional means remaining emotionally reserved and distant from the patient." Tronto writes that "one of the central tasks for people interested in care is to change the overall public value associated with care. When our public values and priorities reflect *the role that care actually plays in our lives*, our world will be organised quite differently" (Tronto, 1998, p. 16, my emphasis). We sometimes act like what we do does not affect others, when it always does. The task is to bring care and justice together, to address the inequality and inequity within society, and to translate those values into caring action.

Milton Mayeroff also provides helpful suggestions on how to care better. He explains how caring is a process of "helping the other grow" (1971, p. 3). Within this process of caring, he says, "I *experience* what I care for," whether that be a person, an ideal, or an idea, as "an extension of myself"

(1971, p. 3) He says, “caring is the antithesis of simply using the other person to satisfy one’s own needs” (Mayeroff, 1971, p. 1). However, in being so closely united with another individual in any type of caring relationship (mother to child, husband to wife, or caregiver to patient) Mayeroff argues that you should see the other as deeply connected to you, but also separate from you, where the other becomes something or someone “that [you] respect in its own right” (1971, p. 3). He claims that caring relationships are different from parasitic, morbidly dependent, dominating, or dogmatic relationships in that these other forms of relating fail to do three things: (1) to see the other as independent in its/their own right; (2) to be able to respond to it/them truly; (3) to allow the object, idea, or person to “be itself” and to “grow in its own right” (Mayeroff, 1971, p. 3-4).

Mayeroff also promotes the idea that devotion is an integral companion to caring, because without it caring breaks down. He says, “devotion does not simply measure the extent of my caring, but it is through devotion that caring for this other acquires substance and its own particular character” (p. 5). For Mayeroff, devotion is shown through consistency of caring actions, including showing up or “being there” (p. 6), which also requires persistence from the carer to endure even under what Mayeroff calls “unfavourable conditions” (p. 6). However, this type of devotion (under what I would argue has to be truly caring conditions) is never a burden, because this type of devotion from a carer is chosen through their own free-will. Rather than feeling pressured or forced, there is a lightness in acting through caring devotion, as Mayeroff says “there is a convergence between what I feel I am supposed to do and what I want to do” (p. 6). He gives the example of a father who must rush his child to the hospital in the middle of the night; he argues that the father does not feel a burden in this, instead, he is “simply caring for the child” (p. 6).

Given the suggestions made by many care ethics advocates, and everything I feel we have learned throughout this project up until this point, I want to conclude this chapter by making a few suggestions for how I think we can help caregivers in critical care medicine reduce their overall occupational stress now. Of course, further research on institutional ways to care, individual ways to care, and in the abstract, ways in which we can restructure medicine as a cultural and social discipline to be more caring, are all necessary; I suggest a few simple ways to start this process off.

8.2 Ways to Start Caring Now

Most of the themes identified in this project operate on deep social, political, and psychological levels. Regardless, there are still many ways that caregivers can begin to dismantle the harmful practices of the past, today. Given that many of the themes centre around individual ways of being, as well as collective ways of navigating social environments and the culture of social and educational institutions, we do not necessarily need to reinvent the wheel. The themes I have identified are not new, and there are many proven methods for approaching work psychology, workplace safety and culture, and workplace wellness through targeted education, professional support, peer support, and opportunities for practising wellness.

For areas like critical care that are very insulated and consist of a very particular group of professionals, these environments would strongly benefit from having education sessions that teach professional boundaries, personal strategies for managing stress, and how to manage moral distress, ethical dilemmas, and conflict in the workplace. These teams would also greatly benefit from having regular debriefs to unpack their emotions, time that is set aside to honour and grieve for patients, ways to engage in peer-support, and be given access to nurse-led initiatives designed to support the unit (e.g., team building), and access to counselling services. These initiatives would provide caregivers with a more comprehensive review of how individuals can best care for themselves *while* working within the confines of the ICU where stressful relationships are unavoidable.

Mental health training and ethics education opportunities also give providers a chance to discuss these difficult situations and to develop stronger emotional intelligence, self-acceptance, and self-knowledge. Mental health supports provide individuals with many positive coping strategies for the workplace and at home, and ethics education can help caregivers learn how to better tackle conflicting values, conflicting beliefs, and conflicting circumstances in hospitals. To make time for emotional work to happen, caregivers must be given a platform to do this work. They need safe places to talk, caring people to listen, and competent professionals to guide them. Engaging in emotional work will require expert-led guidance at times and 'protected time' for caregivers to practice these new skills since gaining competence in these areas might be likened to using a muscle that you haven't used in a very long time – it will take practice to undo previously engrained ways of being that were unhealthy.

Having experts who can effectively facilitate emotional work is important because some of the stressor's employees face will require different skill sets, including human resource workers, quality improvement specialists, psychologists or counsellors, trauma workers, bioethicists or legal advisors, or even spiritual care and chaplains, depending on the concerns being raised. People trained to conduct debriefings, provide education, and instruct individuals on how to best navigate difficult situations are important when you are dealing with caregivers who work in high stress environments where patients can die, meaning, you never want to make things worse by haphazardly delivering 'care' that could end up being quite 'uncaring' at the end of the day. Emotional work also does not need to force individuals to talk, reveal secrets, or even re-live their trauma (which can further traumatise them); instead, acknowledging stress and trauma can be a gentle process, one that simply requires acknowledging how a person feels in certain situations, how certain people, events, sounds, smells, affect them (e.g., difficult emotions, discomfort, anxiety, even flashbacks or nightmares) and slowly developing tools with experts to begin feeling better.

The technicalities and steps involved with implementing these strategies successfully for healthcare institutions are outside the scope of this project, so I will leave my suggestions here. To fully understand the scope of what supports are available, how to properly implement them, and what feedback caregivers would provide in response, all require more research and further explorations into occupational wellness strategies. At this point, I have only pointed to a primary area of care that needs our immediate focus: the need to bring emotion back into medicine.

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Appendices

Appendix 1: Raw Data and Coding – Samples of the Categorization Process

Raw Narrative Data and Codes	The Iterative Process (Comparing Similar Narrative Data with Codes)	Resulting Categories or Themes
One day a nurse mistook me for a doctor and called me the resident. It took me a minute to correct them. I liked being presumed to be a physician for a moment, it felt good. It felt better than my current title. Physicians seem to garner respect and are treated with dignity in this system. [Code – Personal Identity] Some physicians are so dedicated and so caring. I remember knowing that a particular surgeon would always be approachable, no matter what. They would always stay in touch with their patients and ensure that no one was suffering ill effects of the system that day. It was such an honour to work with them, and I had this confidence that even if I was lower down on the hierarchy, I would still receive respect from them. [Code – Personal/Professional Identity] When I would arrive in the ICU and see particular charge nurses working, I knew – today was going to be a good day. It was a feeling of knowing I would be supported, knowing I could safely ask questions, and that there was a certain level of respect built between us in our relationship. There were some hard days, but that is to be expected. [Code – Personal/Professional Identity]	Staff used to joke about how great it is to marry doctors. They would say "They work all day, and you get to spend their money." I knew I never wanted that, I wanted my partner to spend quality time with me, and no doctor that I knew had the time for that. [Code – Perceived Nature of the Other] Doctors can be really cruel. I am not sure whether this is due to their perceived sense of authority and power, and therefore, they feel they can act however they want; or if that is just their unique personality. Not all of them are like that, some of them are extremely sweet and caring, but I have been dressed down mostly by doctors, rarely by nurses. [Code – Perceived Nature of the Other] I remember walking around the unit (ICU) collecting data on the patients, and I saw a particular nurse working at the bedside. I know from experience that the interaction will not be pleasant, they may even purposely avoid me or not speak to me. I decided it was just easier to avoid the whole scenario and come back later. It's better when they are on break to look at the patient's information, then there is less tension. [Code – Perceived Nature of the Other]	Category: Identity Concepts • Personal Identity • Professional Identity • The "True" Self • Perceived Nature of the "Other" • Intersectionality of Selves • Intersectionality of Social Categories Summary: What does it mean to be a physician, a nurse, an allied healthcare professional, etc.; what does it mean to be a non-physician, non-nurse, non-allied caregiver, etc.; what types of power relations there are, as well as signs or symbols of status that must be obeyed or not, what beliefs cause unconscious behaviours, what types of treatment towards others is associated with our identities, and the ways in which people interpret others character or motives?
My friend and I visited the OR at nighttime, we were observing surgeries as pre-med students. When swinging open the OR doors, all either of us could see were layers of muscle flaps flayed out in all directions. I wondered, where was the head of the patient? Where were the legs? The process of retrieval seemed to be too far along, meaning we could only orient ourselves by the central swollen abdomen and from what appears to be a few newly	I was shadowing an anaesthesia resident for the night, to better understand the organ retrieval/ donation process. They let me sit and watch as they managed their anaesthesia machines, and I was even able to irrigate the lungs while the transplant team began removing the kidneys. The whole team was so supportive and kind, and very eager to teach. They showed me how the kidney machine worked, to keep the kidney	Category: Awareness Competencies Concepts: • Awareness of the Self - Degree of knowing how one is feeling (high vs. low) • Awareness of Others - Degree of knowing how others are feeling (high vs. low) • Knowledge of the Self - Clearly knowing what you are like or what you need (high

exposed bones. This patient was no longer identifiable, they were a pile of meat. I felt my knees weaken, but I knew I had to look like it did not bother me so the resident knew I could be a doctor someday, so I shook it off, whatever I was feeling. [Code: Awareness of the Self] One day in the OR a patient being treated for a gastro-intestinal bleed died suddenly, after only twenty minutes of being in the operating room. I saw the nurse's face as they entered the office to fill out the death package (post-mortem paperwork). They seemed stunned and almost had trouble asking for the papers. I was worried about them. A short while after, I walked over to the theatre where the patient had died to communicate with the nurse, I could see the buckets of blood on the floor underneath the patient's now-covered body. I thought, is anyone going to talk to the staff involved? The nurse stoically completed the job and sent for the morgue stretcher, we never talked about it again. [Code: Awareness of Others]	stored properly for travel. And the away team told me how they would process the retrieved lungs for the flight. I watched as they pulled out the ruptured spleen and took note of the patient's black and blue swollen eyes, and imagined myself being in this position…opened wide for everyone to see. I felt sad that this was their fate. But everyone was just focused on the retrieval, which was medically very exciting to watch. Later, I did not discuss my feelings with anyone. [Code: Knowledge of the Self] A young patient had just died after a long stay in the ICU. The team was distraught, you could feel the tension and grief in the air. Staff would mention it, they would ask, “Did you hear? It’s so sad,” or “I felt so bad for the family who were devastated when it happened.” However, there was no formal discussion as a healthcare team. There is no acknowledgement of the patient's passing besides what was done for the family. No closure really. I felt bad for the caregivers who were unable to process their feelings. [Code: Knowledge of Others]	vs. low) • Knowledge of Others - through relational connections, knowing what others require as unique individuals. Summary: What does it mean to be aware of something, how does one gain awareness? This category is about self-knowledge, paying attention to feelings, paying attention to thoughts, and understanding one's own unique and individual needs in a situation. We can also better understand others and learn their ways of being in order to respect and honour them.
I was startled one day when the physician snapped at me to “be quiet!” They were doing rounds, and my talking with my colleague must have been too loud. I had a history with this individual, always finding it hard to talk to them, finding their approach to always be jarring or rude. I felt angry at the way I was asked so curtly to basically “shut up” when it was just as easy to say it in a kinder way. I had recently broken up with a partner of seven years, moved out of my home, and left my dog behind, and the person I loved. Her comment washed over me, and I politely said, “Okay, no problem, I am sorry” and stopped talking. I could feel a tear coming, so I went to the bathroom to cry in private, since I would not allow them to see the effect their comment had. [Code: Emotional Overwhelm & Surface Acting]	A patient was being palliated, so the family came in to spend some time with them before the team would be ready to withdraw care. One family member had a guitar which I thought was sweet. I continued to do my work when all of a sudden, I could hear a soft voice singing while they strummed the chords… “All my bags are packed I'm ready to go I'm standin' here outside your door I hate to wake you up to say goodbye But the dawn is breakin' It's early morn The taxi's waitin' He's blowin' his horn Already I'm so lonesome I could die So kiss me and smile for me Tell me that you'll wait for me Hold me like you'll never let me go 'Cause I'm leavin' on a jet plane Don't know when I'll be back again Oh babe, I hate to go”	Category: Emotional Work Concepts: • Emotional Labour ○ Surface Acting ○ Deep Acting • Emotional Repression • Repositories of Unaddressed Feelings • Trauma Responses • Emotional Overwhelm ○ Resentment ○ Anger ○ Grief ○ Sadness ○ Burnout ○ Moral Distress ○ Moral Injury ○ Moral Residue • Emotional Diversity • Emotional Acceptance Summary: Emotional work centralises around the concept of engaging in labour (i.e., expending energy or resources for production) or work to

	As I pretended to work, I listened to these heartbreaking words, and I felt very emotional. I wanted to shed a few tears for the beauty of this exchange, or to somehow show respect to this family; however, I knew it was best to hide my feelings and continue working. [Code: Emotional Overwhelm & Surface Acting]	produce fake feelings, demonstrate fake emotions (a lie), or genuinely change how one is feeling through self-deception or non-acceptance, even through ignorance due to trauma, coping responses, or dissociation. Emotional labour can lead to estrangement from the self.
A patient was brought onto the unit who was young and female, and who a lot of the staff identified with. She had lost her baby and needed a lot of very disfiguring surgeries. The whole team seemed very disturbed by her situation, and the newer nurses seemed very upset caring for her. They could have used some help processing their feelings around caring for this patient. It was brought up multiple times to the administration, but no one ever responded. [Code: Ignoring/Silencing].	A staff member was running around the back of the unit trying to ensure they were attending to their patient's needs. They were taking care of three ICU patients, an unsafe nurse-to-patient ratio. They grabbed a blood vial and ran past me to stop the sound of the monitor going off in bed 4, and muttered something about how the other unit couldn't send help because they needed it themselves. "They have double the number of staff that we do!" they proclaimed. [Lack of Trust/Alienation]. The nurse explained to me that she simply could not take care of this patient anymore. "It's torturing them," she explained. She recounted how every time she had to suction the patient's trach or move them to clean or reposition them, their eyes would seem so scared and in pain. The nursing manager had put her on leave until the patient could be discharged or until they died. [Degrading Integrity].	Category: Trust and Integrity Concepts: ● Trusting the self ● Trusting colleagues ● Trusting your department ● Trusting your supervisors ● Trusting management ● Trusting the hospital ● Trusting the institution ● Integrity is a person's sense of wholeness and can be eroded if they are asked to compromise or go against their own values. ● Continually eroding integrity can result in moral injury and trauma, as well as burnout or general apathy towards one's professional role. ● Ignoring or silencing staff can result in a lack of trust due to an overwhelming sense of not being respected or listened to. This can also break trust. Summary: I am interested in questions about how trusting caregivers are and what reasons they have been given to trust their institution. How often are caregivers asked to compromise their integrity for the purpose of executing rules or policies that can be dehumanising or separated from what caring activity should look like?
Every time I would try to help prioritise a patient who was booked on the emergency waitlist for surgery, I would consistently fail to deliver that promise. Hours would go by, then days, as I misleadingly told them how they were "so close" and were "sure to have surgery soon." Without fail, another	A nurse walked by the ICU bed where the curtain had been drawn. "Hey girl, that patient's dead in case you didn't know," they said partially smiling. "Oh my," I said in return, "I've been standing here for a half hour and didn't look up to notice… thanks for the heads up," I told her. She said, "The morgue	Category: Alienation Concepts: ● A problematic separation from patients. ● A problematic separation from caring work (such as patient contact, talking to

emergency would be booked, and the patient would be bumped for another few days or weeks. I could tell how they were losing faith in me and no longer believed what I told them. I honestly stopped believing that I could help them. It became clear over the years that there was little sense in trying so hard. [Alienation/Lack of Care].	stretcher should be here soon, so I'd hurry up if I were you!" [Desensitisation] I watched as a nurse ran around the ICU with her nursing notes in hand (the paperwork where they record all of their caring activities) drawing up drugs and trying to find someone to help her turn her patient. She spent hours writing, checking pumps, and helping her colleagues. I think the only real contact she had with her patients was when she brought them a glass of water and asked them to report how they were feeling. [Alienation from Tangible Care Work].	patients, compassion and empathy, or emotional support). ● Over technologization of healthcare. ● Desensitization to the need for care. ● Trying to help, but failing so often that one stops trying. Summary: Are caregivers separated from the core work that nursing staff used to be known for as a profession? Is there a gap between the ways in which caregivers may have connected with patients in the past, versus how they now rely on wires and monitors to alert them of any issues?
A surgeon was crowded around their friends discussing the day's work and how many new nurses there were lately. "It's a lot to get to know," a resident said, to which the surgeon said, "Well what does an OR nurse really do? They just hand me the equipment, there is literally nothing to know". [Disregard/Disrespect, Cruel/Callous Behaviour].	I sat at the OR desk sifting through the emergency bookings for the day. A surgeon approached the desk and silently filled out a booking form. "Hello," I said, "would you like me to book this case for you?" I was met with silence. A few seconds later they replied, "Put this as the first case, I don't care what anyone else said to you." "Okay," I replied, and since it was Christmas I added, "Are you doing anything exciting with your kids this year?" "Fuck my kids," they said and walked away down the long OR hallway. [Silencing, Verbal Abuse]. After a long day in the ICU, I decided to cover an OR shift since someone had called in sick. I noticed that it was quite quiet. After about an hour I noticed a surgeon pop their head inside the inner core. They said, "I brought a patient down to the room, can you get the staff ready?" I stared at them mouth agape because this was completely against our protocol. You are never supposed to bring a patient to the OR without booking them, calling the team, ordering the equipment, and determining that patient's priority level. They said "Okay I'm waiting on you to organize it" as they walked back to their OR room. I stood still for a few seconds and then called the charge nurse. "This is not going to go over well," I thought. But surgeons could do whatever they wanted. [Lack of Respect, Crossing Boundaries…].	Category: Care Concepts: ● Speaking up ● Advocating ● Being true to you ● Accepting one's feelings. ● Asking for help ● Telling the truth ● Maintaining boundaries ● Monitoring feelings ● Helping the body first ● Thoughts ● Feelings ● Self-care ● Self Love ● Caring Behaviours and four phases/steps (Tronto) Summary: What does a caring institution look like? How do caregivers care about the work they do, for patients, and for each other? What components of care are required for it to function properly? Can we make people care? Does it matter if people don't care? How do caring activities relate to feeling less stressed in the workplace? This category is about analysing our deeply held values, examining our behaviours, and looking at the various micro and macro injustices of healthcare. This category speaks to social relationships and personal ways of behaving at work.

Appendix 2: Thematic Analysis from Coded Data – Qualitative Evidence of Themes

Theme	Analysis	Relevance to Occupational Stress
Identity building as a means of fitting in/belonging; and affects an individual's power	Identity in this project refers to both one's personal identification with oneself (e.g., personality, traits, tendencies, wants, needs, beliefs, thoughts, and behaviours) as well as one's professional identification with the self (e.g., professional title, expertise, power, strengths, weaknesses, styles of work, ways of working, professional relationships, etc.).	Ways of being Ways of acting Ways of interpreting Ways of thinking about the workplace Ways of processing trauma or hardship Ways of fitting in or belonging
Awareness of the self and others as a mechanism for change	Knowledge/understanding of the self, as well as the ability to notice how the self thinks, feels, acts/behaves is necessary to clearly see how our actions affect others. Awareness constitutes an ability to see oneself, and to be aware of what you are always doing in the body, mind, emotions, and spirit. This also summarises one's ability to notice others, and their wants, needs, behaviours, and actions.	Acknowledging facts Knowing the self Knowing one's needs Knowing one's beliefs Knowing one's thoughts Knowing one's feelings Knowing one's actions Seeing both the good and the bad
Emotional work as an unnecessary labour that falsely portrays the nature of human emotion	The resulting overall harm that comes from constantly adhering to feeling rules does sit heavily on the conscience of the caregiver. One of the most salient harms I have witnessed would be the detrimental effects that come from the systemic need to continue to the next patient or task as quickly as possible, a need that removes the possibility of taking time to process sad events, address a patient's feelings, or process one's own feelings prior to and after a patient's death. Emotional work takes time and effort to avoid feeling naturally occurring emotions, which is harmful to the individual and further perpetuates a false narrative and a false world in which we experience people who refuse to feel authentic.	Gruelling labour Unnatural labour Unfair labour Falseness and inauthenticity Blocking of natural feelings Fear of vulnerability and emotion Fear of judgement Fear of ostracization False beliefs around normal emotion Trauma (dissociation) Unhealthy coping mechanisms Denying the truth of what one feels Failure to create authentic bonds or relationships. Inability to process other's emotions
Relational Security, trust, and integrity in the workplace must be preserved for health and wellness	Trust is a very important part of healthcare and medicine. Patients and providers engage in very intimate work that requires a lot of faith in each other in vulnerable moments. When the institution, management, or even colleagues do not trust each other, it becomes much harder to care about one another. It also becomes harder to stay in one's job if there is no sense of security. Actions that break trust include many things, one example being the act of asking caregivers to compromise their own integrity by breaking their values.	Broken trust Broken promises Lies, deceit, or falsehoods Ignoring important factors Silencing those who speak up Avoiding dealing with major events Forcing staff to do things that go against their values Not respecting a person's values Not respecting a person's needs or wishes Not promoting a healthy work environment
Alienation from the self and the production of the creative aspects of	Alienation has the effect of making workers feel exploited and separated from the fruits of their own labour. Caregivers provide patients with a service and a "good," which can be summarised as caring	Losing a sense of purpose Losing a connection with patients Losing a connection with one's role Losing interest in the work itself

caring work is detrimental	activities. Engaging in care work does require a specific part of oneself, including but not limited to, having an emotional connection, feelings of sympathy and compassion for others, being able to put yourself in another person’s shoes, and being able to intuit a need for care. When caregivers are needlessly separated from the creative and healing work they do by technology, paperwork, and corporate processes, they become separated from both the object of their care (the patient) and the process of exacting truly caring actions.	Forgetting the meaning of one’s work Feeling apathetic towards patients or colleagues Feeling apathetic towards the institution Wanting to leave the profession Wanting to do less work
Care work as a means of oppression, or as a means for liberation, inclusion, and wellbeing	Care work is a vital aspect of being human, and it was not always professionalised. Caring about, caring for, caregiving, and care receiving, are all activities that take place daily between the billions of people on the earth. This work is sometimes highly valued (e.g., a doctor caring for a patient) and sometimes considered to be less valuable (e.g., a housekeeper cleaning the washrooms). Care work by critical care staff is reportedly valued, however, the state of occupational stress shows how staff themselves are not being adequately cared for or supported to better care for themselves.	Caring about oneself Caring about others Caring about the work Caring about the patients Caring about the institution Caring if someone is not thriving Caring if someone needs help Noticing and caring if someone is stuck Acting on a need for care Caring well Caring competently Valuing care work as inherently needed.

Appendix 3: Strategies Nursing Professionals Adopt to Cope with Occupational Stress

Characterization of the selected studies according to authors, publication year, type of study, sample and coping strategies, 2017.

Authors	Year	Type of study	Sample	Coping strategies
Kolhs et al.[11]	2017	Qualitative	34	• simple • Individual strategies: getting it off one's chest with some relative at home, leisure / physical activities, self-controlling, silence, letting it all out and crying • simple • Collective strategies: unity, friendship and talks with staff / professionals, having a good time with patients and staff
Moraes et al.[12]	2016	Quantitative	23	• simple • Self-controlling • simple • Positive reappraisal • simple • Social support • simple • Distancing • simple • Problem solving
Miorin et al.[13]	2016	Qualitative	13	• simple • Avoiding any relationship with patients—emotional barrier • simple • Talks with staff—expressing feelings • simple • Leisure (gym, reading) • simple • Religiousness

Authors	Year	Type of study	Sample	Coping strategies
Silva et al.[14]	2015	Quantitative	193	• simple • Problem-focused coping (approaching stressors to solve stress–causing situations, managing or modifying problems) • simple • Seeking social support (instrumental, emotional and / or informational support in the workplace)
Benetti et al.[15]	2015	Quantitative	209	• simple • Positive reappraisal • simple • Social support • simple • Problem solving
Ribeiro et al.[16]	2015	Quantitative	89	In order of frequency: • simple • Problem solving • simple • Positive reappraisal • simple • Social support • simple • Accepting responsibility • simple • Self-controlling • simple • Escape–avoidance • simple • Distancing

Authors	Year	Type of study	Sample	Coping strategies
				• simple • Confrontation
Umann et al.[17]	2014	Quantitative	129	• simple • Control (most frequently used in units for admission of critical or potentially critical patients) • simple • Symptom management (most frequently used in the nephrology unit)
Umann et al.[18]	2014	Quantitative	18	• simple • Control • simple • Avoidance • simple • Symptoms managing
Monteiro et al.[19]	2013	Quantitative–qualitative	8	• simple • Denial and dismissal of suffering • simple • Rationalization • simple • No personal / human contact with patients • simple • Avoidance or quitting the profession • simple • Staying calm / quiet • simple • Paying more attention at work • simple • Change of hospital section

Authors	Year	Type of study	Sample	Coping strategies
				• simple • Self-help books, swimming • simple • Therapy to cope with patients' death
Souza et al.[20]	2013	Qualitative	14	• simple • Emotion–focused: escape–avoidance and positive reappraisal • simple • Problem-focused: accepting responsibility (providing competent care) and seeking social support
Kleinubing et al.[21]	2013	Quantitative	12	• simple • Control • simple • Escape–avoidance • simple • Symptom management
Umann et al.[22]	2013	Quantitative	18	• simple • Control • simple • Avoidance • simple • Symptom management
Jaskowiak et al.[23]	2013	Qualitative	11	• simple • Religiousness • simple • Medication (amitriptyline)
Gomes et al.[24]	2013	Quantitative	96	• simple • Planning

Authors	Year	Type of study	Sample	Coping strategies
				• simple • Active coping • simple • Acceptance • simple • Distractions • simple • Positive reappraisal
Guido et al.[25]	2012	Quantitative	9	• simple • Problem solving • simple • Positive reappraisal • simple • Social support • simple • Escape–avoidance
Guido et al.[26]	2011	Quantitative	143	• simple • Problem solving • simple • Positive reappraisal • simple • Social support • simple • Escape–avoidance • simple • Accepting responsibility • simple • Self-controlling

Authors	Year	Type of study	Sample	Coping strategies
				• simple • Distancing • simple • Confrontation
Negromonte and Araujo[27]	2011	Quantitative	31	• simple • Positive reappraisal • simple • Accepting responsibility • simple • Social support • simple • Distancing • simple • Problem solving • simple • Self-controlling • simple • Confrontation • simple • Escape–avoidance
Hanzelmann and Passos[28]	2010	Qualitative	25	• simple • Getting rid of responsibility (transferal of problems to supervisors) • simple • Problem sublimation (escape) • simple • Foreseeing and solving problems
Silveira et al.[29]	2009	Quantitative	19	• simple •

Authors	Year	Type of study	Sample	Coping strategies
				Strategies in the workplace: establishing and maintaining dialogue; putting oneself in the other's place; mutual help among colleagues; solving conflict; seeking professional improvement; good humor; calm; attention; cordiality and respect to employees, patients and their relatives; not conveying one's stress to patients; providing more humane care of high technical quality resulting in personal satisfaction • simple • Strategies outside the workplace: leisure activities; visiting the beauty salon; meditation; relaxing; massage; psychotherapy; spending time with family; forgetting what happened at the hospital; giving the due value to life outside the hospital; having time for oneself
Pereira et al.[30]	2009	Qualitative	28	• simple • Staying away from the unit for a while • simple • Focusing on work activities • simple • Breathing deep and reflecting on the relevance of one's job • simple • Leisure activities after shifts
Martins and Robazzi[31]	2009	Qualitative	8	• simple • Seeking support in religiousness • simple • Staff support and friendship • simple • Physical activity • simple • Distancing oneself from terminal patients and not involving oneself with relatives

Authors	Year	Type of study	Sample	Coping strategies
Salomé et al.[32]	2009	Qualitative	14	• simple • Alternative medicine (Bach flower remedies, Reiki) • simple • Relaxing (baths) and listening to music at home
Pagliari et al.[33]	2008	Qualitative	11	• simple • Denial • simple • Escape • simple • Seeking nursing supervisors or other members of the multiprofesional staff
Calderero et al.[34]	2008	Quantitative–qualitative	45	• simple • Avoidance (forgetting stressors, blocking emotions, delaying confrontation) • simple • Direct confrontation (speaking about problems, negotiating alternatives) • simple • Indirect confrontation (releasing tension—religiousness, sports)
Rodrigues and Chaves[35]	2008	Quantitative	77	• simple • Positive reappraisal • simple • Problem solving • simple • Self-controlling

Appendix 4: Beehr & Newman, Facets of Job Stress (1978)

BEEHR AND NEWMAN (1978)
TABLE I
Facets of the Job Stress-Employee Health Research Domain
Facets and types of Elements

ENVIRONMENTAL FACET

a. *Job demands and task characteristics*
    -weekly work schedule*
    -over- and under-utilisation of skills*
    -variance in workload
    -pace of work
    -responsibility (for people or for things)
    -travel as part of the job
    -job characteristics thought to be intrinsically motivating
b. *Role demands or expectations*
    -role overload*
    -role conflict*
    -role ambiguity
    -formal and informal relationships among role set members
    -psychological contract perceived by the employee
c. *Organisational characteristics and conditions*
    -company size*
    -job security
    -hours of work (both total and time of day)
    -duration of work tasks -socio-technical changes
    -organisational structure (and job's position within hierarchy)
    -communication system (and job's position within system)
    -subsystem relations
    -staffing policies and procedures
    -management style (philosophical and operational)
    -evaluation, control, and reward systems
    -training programs
    -organisational climate
    -opportunity for advancement
    -required relocation
    -local union constraints
d. *Organisation's external demands and conditions*
    -route to and from work
    -number and nature of customers or clients
    -national or international unions
    -governmental laws and regulations
    -suppliers; providers of needed services
    -weather
    -technological and scientific developments
    -consumer movements
    -geographic location of organisation

PERSONAL FACET

a. *Psychological condition (personality traits and behavioural characteristics)*
    -Type A*
    -ego needs*
    -need for clarity/intolerance of ambiguity*
    -introversion/extroversion
    -internal/externality
    -approval seeking
    -defensiveness
    -impatience
    -intrapersonal conflicts (e.g., between ego-ideal and reality)
    -self-esteem
    -motives/goals/aspirations (career, life)
    -typical anxiety level
    -perceptual style
    -values (human, religious, etc.); personal work standards
    -need for perfection
    -intelligence
    -abilities (especially task- and coping-related)
    -previous experience with stress
    -satisfaction with job and other major aspects of life
a. *Physical condition*
    -physical fitness*/health
    -diet and eating habits
    -exercise, work, sleep, and relaxation patterns

b. *Life-stage characteristics*
-human development stages
-family stages
-career stages
c. *Demographics*
-age*
-education (amount and type)*
-sex
-race
-socio-economic status
-occupation, avocation

PROCESS FACET

a. *Psychological processes*
-perceptions* (of past, present and predicted future situations)
-evaluation of situation
-response selection
-response execution
b. *Physical processes*
-physiological, biological
-neurological
-chemical

HUMAN CONSEQUENCES FACET

a. *Psychological health consequences*
-anxiety, tension*
-depression *
-dissatisfaction, boredom*
-somatic complaints*
-psychological fatigue*
-feelings of futility, inadequacy, low self-esteem*
-feelings of alienation
-psychoses
-anger
-repression, suppression of feelings and ideas
-loss of concentration
b. *Physical health consequences*
-cardiovascular disease*
-gastrointestinal disorders*
-respiratory problems
-cancer
-arthritis
-headaches
-bodily injuries
-skin disorders
-physical/physiological fatigue or strain
-death
c. *Behavioural consequences*
-dispensary visits*
-drug use and abuse (including alcohol, caffeine, nicotine)*
-over or under-eating
-nervous gesturing, pacing -risky behaviour (e.g., reckless driving, gambling)
-aggression
-vandalism
-stealing
-poor interpersonal relations (with friends, family, coworkers)
-suicide or attempted suicide

ORGANISATIONAL CONSEQUENCES

-changes in quantity, quality of job performance*
-increase or decrease in withdrawal behaviours (absenteeism, turnover, early retirement)
-changes in profits, sales, earnings
-changes in ability to recruit and retain quality employees
-changes in ability to obtain raw materials
-increase or decrease in control over environment
-changes in innovation and creativity
-changes in quality of work life
-increase or decrease in employee strikes
-changes in level of influence of supervisors
-grievances

ADAPTIVE RESPONSES FACET

a. *Adaptive responses by the individual*
-meditation
-manage desires, ambitions, drives
-attempts at increased self-understanding
-vicarious stress reduction (audience activities for sports, drama) -relaxation techniques
-acceptance of less than perfection
-mastery of the environment (including stressors)
-seeking sympathy or social support
-tension release (laughing, crying, attacking)
-leaving the stressful situation (permanently, temporarily)
-adjusting work activities to biorhythms
-seeking medical, psychological, other professional help
-attempts to alter behavioural, personality style
-planning, organising each day's activities
-use of biofeedback techniques
-reduction of psychological importance of work
-increased religious activity
-quitting drug intake
-find more suitable job
-setting realistic goals
-physical activity
-diet
-getting sufficient rest

b. *Adaptive responses by the organisation*
-redesigning jobs
-altering organisational structure
-changes in evaluation, reward systems
-changes in work schedules
-providing feedback to employees aimed at role clarification
-refine selection and placement procedures; include job stress as validation
-provision of human relations training
-marking career paths and promotion criteria clear
-communication improvement
-provide health services

c. *Adaptive responses by third parties*
-attention to career guidance by school systems
-alcohol and drug abuse treatment programs
-legislation regarding quality of work life, health care, mandatory retirement
-social support by family and friends

TIMEFACET
-time as a variable in development of stress
-time as a variable in response to stress
-time as a variable in relationships among facets 1-6
-sequential reactions (chain and cyclic)